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MEDICAID AND MEDICARE PART B BUDGET RECONCILIATION AMENDMENTS OF 1982

AUGUST 17, 1982.—Ordered to be printed

Mr. DINGELL, from the Committee on Energy and Commerce, submitted the following

REPORT

together with

DISSENTING AND SUPPLEMENTAL VIEWS

[To accompany H.R. 6877 which on July 28, 1982, was referred jointly to the Committee on Energy and Commerce and the Committee on Ways and Means]

[Including cost estimate of the Congressional Budget Office]

The Committee on Energy and Commerce, to whom was referred the bill (H.R. 6877) to amend title XIX and part B of title XVIII of the Social Security Act to provide for budget reconciliation for fiscal years 1983, 1984, and 1985, having considered the same, report favorably thereon with amendments and recommend that the bill as amended do pass.

The amendments (stated in terms of page and line numbers of the introduced bill) are as follows:

Page 15, line 22, strike out "is amended by adding at the end" and insert in lieu thereof ", as amended by section 104(a) of this Act, is further amended by adding after paragraph (3)".

Page 15, line 24, strike out "(3)(A)" and insert in lieu thereof "(4)(A)".

Page 64, after line 25, insert the following new paragraph:

> (3)(A) Section 1839(d) of the Social Security Act shall not apply to the premiums of individuals enrolled during and pursuant to the enrollment period provided under paragraph (1).
>
> (B) Subparagraph (A) shall not apply to an individual if the individual was previously enrolled in the insurance program under part B of title XVIII of the Social Security Act unless the previous enrollment was terminated solely because the individual lost eligibility to be so enrolled.

Page 65, line 1, strike out "(3)" and insert in lieu thereof "(4)".

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I. Purpose and Summary

The First Concurrent Budget Resolution for Fiscal Year 1981 (S. Con. Res. 92) includes "reconciliation" instructions to the Committee on Energy and Commerce to report recommendations to the Budget Committee for the achievement of certain spending reductions in programs within its jurisdiction.

This bill represents the response of the Energy and Commerce Committee to these reconciliation instructions. This report contains legislative language for recommended changes as well as the explanation of the Committee of its intent concering these provisions.

In summary, the Committee discharged its obligation under the Budget Resolution by recommending changes in various provisions of the Medicaid program (Title XIX of the Social Security Act) and Medicare Part B (Title XVIII of the Social Security Act).

The Committee notes that it shares jurisdiction with the Committee on Ways and Means over the Supplementary Medical Insurance portion of the Medicare program (Part B). In order to avoid arithmetical duplication in responding to the reconciliation instructions, the Committee on Energy and Commerce has included in its recommendations only Medicare Part B provisions that do not replicate changes likely to be adopted by the Committee on Ways and Means.

II. Background and Need for Legislation

As reported, H.R. 6877 contains provisions relating to both the Medicaid and Medicare Part B programs. With respect to Medicaid, the bill would: allow States to impose nominal copayments for most services; allow States to impose liens on the homes of institutionalized Medicaid recipients and to penalize the transfer of such homes for less than fair market value; eliminate the current deadline for States to establish a rate-setting program in order to qualify for an offset against the percentage reductions in Federal matching payments; allow States to qualify for an offset against the percentage reductions in Federal matching payments by lowering the rate of increase in their aggregate inpatient hospital costs; allow States to extend Medicaid coverage in the home to certain disabled children who currently would be covered only in an institution; allow States to extend Medicaid coverage to certain dependent children and relatives who lose eligibility

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for cash assistance due to the modification of certain work incentive provisions in former law; and make corrections reflecting technical errors in the Omnibus Budget Reconciliation Act of 1981 (P.L. 97–35).

With respect to Medicare Part B, the Committee bill would: reduce reimbursement for inpatient hospital radiology and pathology services from 100% of reasonable charges to 80% of reasonable charges; limit the increase in the economic index for prevailing charges for physicians to 4 percent effective October 1, 1982, except for those physicians who agree to accept assignment on all their bills; postpone the next annual update of the economic index from July 1 to October 1, 1982; provide for the reimbursement of Health Maintenance Organizations on a prospectively determined per capita amount equal to 95 percent of the cost of providing Medicare services to beneficiaries outside the HMO; and waive the late enrollment premium penalty for merchant seamen and other individuals who enroll in Part B during a special enrollment period.

These provisions are designed to comply with the reconciliation instructions contained in the First Concurrent Budget Resolution for FY 1983 so as to minimize the adverse impact on program beneficiaries, the States, and participating providers.

A summary of the provisions of the bill follows:

Short title (section 1)

This Act may be cited as the "Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982."

TITLE I—MEDICAID SAVINGS

Permitting nominal copayments for most services (section 101)

The bill authorizes States to impose nominal copayments on mandatory services (other than emergency services and family planning services for the categorically needy (other than children under 21, pregnant women, and persons in nursing homes).

Under current law, States may impose nominal copayments on optional services for both categorically needy and medically needy beneficiaries. In addition, States may impose copayments on mandatory services provided to the medically needy. However, States are precluded from imposing copayments on mandatory services offered to the categorically needy. Standards for nominality are set forth in current regulations.

The bill authorizes, but does not require, States to impose nominal copayments on the categorically needy for most mandatory services. The bill also exempts certain services and certain groups of beneficiaries from any copayments or other forms of cost-sharing altogether.

Two types of beneficiaries are exempted from any cost-sharing obligation, whether they qualify for Medicaid as medically needy or as categorically needy: pregnant women and children under 21. With respect to pregnant women, the Committee notes the findings of the Select Panel for the Promotion of Child Health, whose 1981 report, "Better Health for Our Children: A National Strategy," stressed the importance of comprehensive, medical, dental, and supportive services during the course of pregnancy. Since the overall health status of a

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pregnant woman has such a profound effect on birth outcomes for both the mother and the child, the Committee deems it essential to avoid placing any economic barriers to a woman's access to needed pregnancy, delivery, or post-partum care. Accordingly, the Committee bill prohibits the imposition of copayments or any other form of cost-sharing on any care or services furnished to pregnant women. This exemption from cost-sharing applies not only to care and services related to pregnancy, including post-partum care (no less than 6 weeks from the time of delivery), but also to any other covered services. The Committee sees no medically appropriate or administratively practicable means of distinguishing between "pregnancy related" and other services for purposes of cost-sharing, and it wishes to avoid confusion on the part of pregnant women as to whether a given service is subject to cost-sharing.

The other class of beneficiaries exempted from cost-sharing is children under 21. This exemption applies whether children qualify as categorically or medically needy, and regardless of whether the services they need are mandatory or optional. Whatever the merits of cost-sharing as a deterrent to unnecessary use of medical services among low-income adults, there is in the Committee's view no justification for denying a poor child services because of that child's family's inability to pay. Repeated studies, cited by the Select Panel, demonstrate that the problem confronting low-income children is underutilization, not overutilization, of medical care.

The Committee bill also exempts from cost-sharing obligations two classes of categorically needy beneficiaries: inpatients in skilled nursing or intermediate care facilities, and persons enrolled in Health Maintenance Organizations. The Committee sees no purpose to the imposition of cost-sharing requirements on institutionalized individuals who, in effect, are already subject to extensive cost-sharing, since they are required to spend all of their income for medical expenses (other than a very small personal needs allowance). Cost-sharing in this circumstance will not deter use of medical services; it will only create unnecessary administrative expense. With respect to HMO enrollees, the Committee is of the view that cost-sharing requirements are unnecessary to control utilization in the context of an HMO, where fixed, prospective payment already creates strong economic incentives to avoid overutilization.

With respect to other beneficiaries, the Committee bill allows States to impose nominal cost-sharing on all services except emergency services (as defined by the Secretary); family planning services and supplies; and care and services related to pregnancy (including post-partum services). Whether these services are offered to the categorically needy or the medically needy, the Committee bill prohibits the States from imposing any copayments with respect to them. In the Committee's view, copayments have no justification in the context of emergency services; they serve only to burden the beneficiary and the provider. The Committee bill leaves to the Secretary the task of establishing a definition for emergency services that will be applied uniformly in those States electing to impose copayments. At a minimum, any definition of emergency services should give appropriate weight to the judgment of qualified medical personnel at the time of presenta-

tion for services as to whether denial of care would be likely to result in death or severe permanent physical or mental damage.

The Committee bill only permits States to impose copayments that are nominal in amount. The purpose of this limitation is to prevent States from imposing copayments or other cost-sharing requirements that are likely to deter beneficiaries from seeking medically necessary services. In the case of inpatient hospital services, cost-sharing for the categorically needy may not exceed $1 per day. In the case of outpatient hospital services, physician services, and clinic services, cost-sharing for the categorically needy may not exceed $1 per visit. With respect to other services for the categorically needy, the Committee bill requires that any cost-sharing be nominal in amount.

The Committee expects that, in promulgating regulations establishing standards for nominality, the Secretary will take into account the income actually available to beneficiaries. For example, as of November of 1981, the maximum benefit payment to which an AFDC mother and two children were entitled in Alabama was $118 per month; the comparable level in California was $506. The cost-sharing expected of such a family in Alabama, if any, should be considerably lower than that expected of a family in California. Moreover, because the incomes of the categorically needy are generally lower than those of the medically needy, the cost-sharing obligations for the former should generally be lower than those for the latter. The Committee bill does not alter the current regulatory standards for nominality as applied to the medically needy; the Committee reviewed these standards and finds it unnecessary to disturb them (athoughe, as previously mentioned, it has found it necessary to exempt certain classes of beneficiaries altogether).

The Committee bill contains one exception to the principle that copayments must be nominal: When a beneficiary, whether categorically or medically needy, receives nonemergency services at the emergency room of a hospital. Where these nonemergency services are readily available elsewhere, such as a nearby outpatient clinic or physician's office, States may impose charges that will deter misuse of the emergency room, up to $4 per visit. However, before imposing such charges in any given locality, the State must establish, to the satisfaction of the Secretary, that beneficiaries using a hospital emergency room have actually available and accessible to them alternative sources of nonemergency, outpatient services. Such a determination should take into account factors such as the number of ambulatory care providers who participate in Medicaid in the catchment area served by an emergency room; the service capacity of each provider; and the geographic accessibility of the alternative providers.

The Committee recognizes that in many instances it may be difficult for providers participating in the program to collect even nominal copayments from indigent beneficiaries. The Committee does not intend that the States use the authority to impose copayments in order to reduce provider reimbursements. Nor does the Committee intend that nominal copayments create barriers to care for beneficiaries. Accordingly, the Committee bill prohibits any provider participating in the Medicaid program from denying care or services to any eligible beneficiary because of that person's current or previous inability to meet a cost-sharing obligation.

The Committee notes that a large number of States have sought waivers of current law relating to the imposition of cost-sharing under the demonstration authority at section 1115 of the Act. The Committee believes that this bill gives the States sufficient flexibility in this regard to make further exercise of the Secretary's demonstration authority unnecessary.

Recovery of costs and disposal of home in the case of institutionalized medicaid recipients (section 102)

The Committee bill allows States, at their option, to impose liens on the homes of institutionalized beneficiaries and to penalize the transfer of a home by such persons for less than fair market value within two years prior to application for benefits.

Under current law, State are prohibited from imposing liens against the real or personal property of Medicaid beneficiaries prior to death, except pursuant to a court judgment involving benefits that have been incorrectly paid. States may not actually execute liens on property to recover Medicaid funds paid out on behalf of elderly beneficiaries unless (1) the beneficiary has died, (2) the surviving spouse has died, (3) the beneficiary has no blind or disabled child, and (4) the beneficiary has no child under 21.

Current law also allows States to impose penalties, in the form of denial of Medicaid eligibility for specified periods of time, on individuals who transfer assets for less than fair market value up to two years before applying for benefits in order to qualify for Medicaid. These penalties can be no more restrictive than those to which Supplemental Security Income (SSI) recipients are subject. Current SSI policy considers an individuals' home an exempt resource; thus, States are precluded from denying Medicaid coverage to individuals who transfer their homes for less than fair market value. In some instances, this has allowed individuals to receive Medicaid coverage for nursing home care while denying the State the opportunity to recover its costs from the individuals' real property.

The Committee bill gives States the opportunity to protect their interest in recovering Medicaid costs from the sale of the home of a nursing home patient after death by deterring transfers. The bill authorizes the States to deny Medicaid benefits to individuals who are inpatients in skilled nursing or intermediate care facilities, and who disposed of a home for less than fair market value within two years of applying for benefits. The option of denying eligibility for disposal of a home applies only to those persons whom the State, after notice and opportunity for a hearing, establishes are reasonably likely to remain in the facility as inpatients for the remainder of their lives. Individuals who do not enter a nursing home, or who expect to be discharged from the facility and return home, are not subject to this transfer prohibition.

In the case of persons who are otherwise subject to this prohibition, the Committee bill identifies three situations in which eligibility for Medicaid cannot be delayed by a State. The first is when the individual transferred title of the home to his or her spouse, child under 21, or child who is blind or disabled. The Committee sees no justification for deterring transfers of homes to spouses or dependent children.

Secondly, the bill does not authorize denial of Medicaid eligibility in cases where the individual can demonstrate that he or she intended to dispose of the home at fair market value or for other valuable consideration. It would not, in the Committee's view, be equitable to penalize elderly individuals who believed they were receiving a fair price for their home, but due to lack of familiarity with the real estate market or incorrect or self-serving advice, failed to realize an adequate price. Similarly, it would be inappropriate to penalize an individual for transferring a home to another in consideration for care and support provided during part or all of the individuals' life. The Committee believes that Federal policy should encourage arrangements under which relatives or friends take care of an individual at home with the formal or informal understanding that, when institutionalization can no longer be avoided, the caregiver would receive title to the home in compensation for services rendered.

Finally, the transfer of assets prohibition would not apply in cases where the States determines that denial of eligibility would work an undue hardship. For example, an individual may transfer title to a home to an adult child for little or no consideration, on the expectation that the child would care for him. The child himself may become disabled, however, and be forced to sell the property and apply the proceeds to his own care. Neither he nor any other family member would be in a financial position to care for the individual. In such circumstances, it would serve no purpose to deny Medicaid coverage, since the individual has no other source of needed care.

Under the Committee bill, the period of ineligibility to which an individual is subject must be computed so that the cost of the services that would be furnished to the individual during the period bears a reasonable relationship (in accordance with regulations promulgated by the Secretary) to the amount of the uncompensated value of the home. In determining the cost of the services, States must use the maximum rates they would pay for nursing facility services under their Medicaid plans. In determining the uncompensated value of the home, States must consider only the individuals' actual equity in the property; in those instances where the equity is less than the market value, the uncompensated value should exclude any amounts remaining to be satisfied on the mortgage. The Committee expects that in promulgating regulations implementing this provision, the Secretary will require as close a correspondence between the costs of services and the uncompensated value as is administratively feasible. The purpose of the provision is to deter such transfers through in-kind recoupment of the government's expenditures, not to punish them through long periods of ineligibility that are disproportionate to the uncompensated value. The Committee also notes that some State codes provide for recovery of a transferred asset by the State Attorney General or other official. The Committee intends that, when such recovery occurs, there no longer be any uncompensated value for which eligibility could be delayed.

The Committee bill also makes a number of changes in current law regarding the imposition of liens on real property. Under the bill, States may, at their option, impose liens on the homes of an individual who is an inpatient in an SNF and who the State establishes, after notice and opportunity for a hearing, is reasonably likely to remain in

the facility for the rest of his or her life. The purpose of this provision is to give the States a mechanism for protecting their financial interest in an institutionalized recipent's home until probate of the estate. If such an individual is discharged from the facility and returns home, then the lien is no longer of any effect.

Under the Committee bill, there are a number of circumstances in which States may not foreclose on a lien even though the recipient has died. As under current law, so long as a spouse, a child under 21, or a disabled or blind child survives, the State may not take the lien on the home. In addition, the Committee bill prohibits the State from executing the lien so long as a sibling, son or daughter (including stepson or stepdaughter) of the beneficiary was lawfully residing in the recipient's home, and had been living there for at least one year prior to the beneficiary's admission to the SNF or ICF. The Committee seeks to encourage arrangements under which close family members care for a frail elderly or disabled person in exchange for the ability to live in that individual's home. While the Committee recognizes that prohibiting foreclosure of the lien upon the beneficiary's death will delay the State's recovery of its costs and probate of the estate, the Committee believes that the resulting incentives for such caretaking arrangements appropriate.

The Committee bill creates an exception to the current law authorizing execution on a lien upon sale of the property subject to the lien. Where the beneficiary's spouse or minor or disabled child is no longer to manage the home and the beneficiary (or the estate) chooses to sell the home, the proceeds are to be placed into a trust, the income of which is to be used for the reasonable care and maintenance of these family members. The terms of such trusts, which may be administered directly by the States or by a private trustee selected by the State, are to be framed by the Secretary. The Committee intends that, in defining reasonable care and maintenance for the spouse or dependent children, the Secretary set a standard that is higher than the applicable Federal poverty guideline. The Committee believes that trust instruments of this type will allow spouses to avoid being locked by the State's lien into homes they can no longer manage while at the same time protecting the State's financial interest in recovering its costs and preventing other family members from becoming public charges.

State flexibility in provider reimbursement (section 103)

The Committee bill eliminates the July 1, 1981 qualifying date for State hospital cost review programs and establishes an alternative performance test for lowering the rate of increase in aggregate hospital costs as a basis for a State to receive an offset against the percentage matching payment reductions enacted in the Omnibus Budget Reconciliation Act of 1981.

Current law, entitles a State with a qualified hospital cost review program to a one percent reduction in the percentage reduction otherwise made in Federal Medicaid matching payments in Fiscal Years 1982 (3%), 1983 (4%), and 1984 (4.5%). This provision recognizes that in States with such programs, the lower rate of hospital inflation produces savings to both the State and the Federal government. In order to qualify for this penalty reduction, a State hospital cost review program must meet a number of specific criteria, including one

requiring the program to have been established by statute prior to July 1, 1981. Under this deadline, only seven States with programs now in operation—Connecticut, Massachusetts, Maryland, New Jersey, New York, Rhode Island and Washington—may qualify for the bonus. States that succeed in reducing their rates of increase in hospital costs through other means cannot qualify for the 1% penalty reduction.

The Committee bill makes two changes. First, it deletes the requirement that a qualified State program be established by July 1, 1981. This amendment will allow States which establish new hospital cost programs in the future to benefit from the one percent bonus if they otherwise qualify. The Committee notes that since the performance test is administered on a retrospective basis, and since data on the increase in hospital costs is not available until nine months after the end of a calendar year, States with new review programs are not likely to qualify for the bonus until Fiscal Year 1985 at the earliest. The Committee also observes that this bonus is a modest one, as the Congressional Budget Office has estimated that it returns less than 15 percent of the savings which accrue to the Federal government from State review programs to the States which have elected to establish and operate such programs.

Secondly, the Committee bill allows States in which the rate of increase in hospital inpatient costs is significantly less than the national average to qualify for a one percent reduction in the reduction in Federal payments without establishing a qualified hospital cost review program. States could, at their election, use this provision or review provision to qualify for a one percent penalty reduction; they may not use both.

This provisions establishes a specific performance test to determine if a State qualifies. The formula for a State's target rate of increase is $R \times (N-2)$. R is defined as the ratio of a State's rate of increase in aggregate inpatient hospital costs (per capita or per admission) to the national rate of increase in such costs in the preceding three years, and N is the national rate of increase in the test year. For States with a higher rate of increase than the nation as a whole during the previous three years, the value of R is set at one.

Under this formula, States in which the rate of increase in aggregate inpatient hosptial costs (per capita or per admission) has been greater than such increase for the nation as a whole in the preceding three years must have a rate of increase in calendar years 1983 or 1984 of at least two percent less than that for the nation as a whole. States with a rate of increase in the preceding three years of less than the national average must maintain their position relative to the national average and, in addition, reduce their rate of increase further by up to 2 percent points. For example, if the rate of increase has been 15 percent in a State and 20 percent nationally, a State's target is to remain at ¾ of the national average, and the State must further reduce its rate of increase by ¾ of 2 percentage points—or 1½ percentage points. If the national rate fell to 16 percent, the new State target would be 10½ percent. If the national average rose to 24 percent, the State target would be 16½ percent.

This provision does not specify the steps, if any, that a State must take to achieve the reduction in hospital cost inflation. The sole test

is performance. The Committee notes that, due to the restrospective nature of the performance test and the delay in the availability of data, the adjustment in payments to States for Fiscal Year 1983 is not likely to be actually made until Fiscal Year 1985, and payments for 1984 will not be actually made until 1986.

Medicaid coverage of home care for certain disabled children (section 104)

The Committee bill gives States the option of providing Medicaid benefits to certain disabled children at home even though they are currently eligible for coverage only in an institution.

Under current law, the income and resources of the families of disabled children under 18 are "deemed" to be available to them so long as they are living at home for purposes of eligibility for Supplemental Security Income (SSI) benefits. Since in many States Medicaid coverage is dependent upon receipt of SSI benefits, and since such children will qualify for SSI if they are placed in a hospital, nursing home, or other long-term care institution, many families have decided to institutionalize. Current SSI law authorizes the Secretary to waive the "deeming" requirements in circumstances he determines to be "inequitable;" to date, this has occurred in one instance, allowing the child involved to qualify for SSI and Medicaid benefits at home.

The Committee bill allows the States, at their option, to make Medicaid benefits available to disabled children under 18 at home even though these children would not be eligible for SSI benefits due to the income or resources of their parents. In order for a child to establish Medicaid eligibility, the State must determine that (1) the child requires a level of care provided in a hospital, skilled nursing facility, or intermediate nursing facility; (2) it is appropriate to provide the care to child at home (taking into account the child's medical condition and needs, the family's ability and willingness to help care for the child, and other relevant factors); and (3) the estimated cost of caring for the child outside of the institution will not exceed the estimated cost of treating the child within the institution (assuming an appropriate level of services in both instances). Children meeting these standards would be eligible for Medicaid even though they were not receiving SSI cash assistance at home.

In the Committee's view, it is, as a general matter, preferable to treat disabled children at home rather than in an institution if home care would be less expensive than in an institution and medically and socially appropriate. It is not the intent of the Committee to allow States to force the discharge of disabled children from institutions simply because care at home would be less expensive for the State if the family is unwilling to help care for the child or if the child strongly desires to remain in the institution. However, in those cases where home care would be no more expensive, is medically and otherwise appropriate, and is what the family and the child want, the Committee believes that States should be allowed to make Medicaid coverage available without seeking approval, on a case-by-case basis, from the Secretary. Making home coverage available on a Statewide basis will avoid the inconsistencies in treatment that might arise under a national case-by-case waiver procedure.

Optional medicaid coverage for certain children and relatives without regard to certain work disincentives imposed by the Omnibus Budget Reconciliation Act of 1981 (section 105)

The Committee allows States to extend Medicaid coverage to families with dependent children who are ineligible for cash assistance under the Aid to Families with Dependent Children (AFDC) program as a result of changes in the treatment of earned income and work expenses.

Under current law, families receiving AFDC benefits are eligible for Medicaid as categorically needy individuals. The Omnibus Budget Reconciliation Act of 1981, P.L. 97–35, made a number of changes in the treatment of earned income and work expenses for purposes of determining AFDC eligibility. The work expense disregard was limited to $75 per month. The child care disregard was limited to $160 per month per child. The earned income disregard ($30 plus one third of the remaining income of a family receiving assistance) was limited to the first 4 months of receipt of AFDC benefits, and the order in which this disregard was computed was altered. The gross income allowed to an AFDC family was limited to 150 percent of the State's standard of need. Finally, individuals eligible for an Earned Income Tax Credit were assumed to have received the credit on an advance monthly basis, even though they had not actually received the credit.

In the Committee's view, the effect of these changes, which substantially reduce the amount of earnings a family can have before losing all AFDC benefits and Medicaid coverage, has been to discourage many AFDC families from seeking or maintaining employment. The loss of Medicaid benefits is of great concern to working parents in AFDC families, because many of them are employed in low-wage jobs where employer-paid health insurance coverage is simply not available. Individually purchased health insurance coverage is usually prohibitively expensive for these families. Thus, working AFDC parents face a difficult choice: continue working; lose AFDC and Medicaid benefits, and go without any insurance protection; or quit work and reestablish AFDC and Medicaid eligibility. The Committee believes that this choice creates a severe and unnecessary disincentive for AFDC families to support themselves through work, particularly families with medical needs.

The Committee bill allows the States, at their option, to continue Medicaid coverage to treat as eligible for Medicaid those families who would be eligible for AFDC benefits but for any or all of the 1981 work disincentives: (1) the $75 per month limitation on the work expense disregard; (2) the $160 per month limitation on child care expenses; (3) the order of computation of the $30 and one third earned income disregard; (4) the 4-month limitation on the $30 and one third earned income disregard; (5) the treatment of an earned income advance amount or EITC credit as income even though not actually received; and (6) the limitation to 150 percent of the State's need standard on the gross income an AFDC family may receive.

The Committee bill allows States to ignore, for Medicaid eligibility purposes, any of these changes, a combination, or all of them. The bill gives States the flexibility to establish higher limitations, if they so choose. For example, a State might choose to raise the limitation on

the work expense disregard from $75 to $150 per month, or it may choose not to set any limit whatsoever. The Committee intends that the Secretary allow the States maximum flexibility in establishing alterantive eligibility requirements for Medicaid under this provision in order to encourage AFDC families to seek and maintain employment. The Committee also notes that this State option is in addition to, and not a substitute for, the four-month extension of eligibility mandated by current law for families losing AFDC benefits due to increases in countable earned income as a result of the 1981 amendments.

Corrections reflecting technical errors in medicaid-related provisions of the Omnibus Budget Reconciliation Act of 1981 (section 106)

The enactment of the Omnibus Budget Reconciliation Act of 1981 brought about extensive changes in the Medicaid, Medicare, and Maternal and Child Health programs, among others. As a result of the extreme time constraints under which these changes were made, a number of errors occurred in drafting the agreements reached by the conferees. As a result, some confusion arose on the part of the Department, the States, and others as to the intent of the conferees. The Committee bill contains provisions designed to remedy these technical errors and clarify the intent of the conferees. These provisions were made available to the Secretary for guidance in administering the programs on December 23, 1981. The following items warrant explanation.

Section 106(a)(3) of the Committee bill amends the October 1, 1981, effective date for Section 2181(b) of the 1981 Reconciliation Act, which repealed the penalty for noncompliance with the Early and Periodic Screening, Diagnosis, and Treatment program standards and incorporated the EPSDT standards into Title XIX of the Social Security Act. The Committee bill amends this effective date to allow States that require legislative action to make the necessary State plan amendments during the next regular session of their State legislature. The bill further provides that the EPSDT standards apply to the States on October 1, 1981, whether or not they have actually been incorporated into the State's Title XIX Plan. The Committee expects that the States will continue to develop fully effective EPSDT programs.

Section 106(b)(4) of the Committee bill clarifies a provision in the new Maternal and Child Health Block Grant, which requires States to give assurances that any charges for health services are public, are adjusted for income, resources, and family size, and are not imposed on low-income mothers or children. The Committee bill clarifies that these charges, whether in the form of deductibles, copayments, coinsurance, or any other billings, must comply with these requirements whether imposed by the State or by a provider of services (when those services are assisted by MCH block grant funds).

Section 106(e)(1) of the Committee bill clarifies the authority of States to provide Medicaid coverage to the optional categorically needy. The 1981 Reconciliation Act amended section 1902(a)(10) of the Social Security Act to give States flexibility in designing service packages and coverage groups in their medically needy programs. On

September 30, the Departemnt of Health and Human Services published an interim final rule intended to implement these provisions, 46 *Fed. Reg.* 47976 (Sept. 30, 1981). In the preamble to these regulations, the Department expresses its view that, in amending section 1902(a)(10), the Congress may have intended to eliminate the "optional categorically needy" individuals for whom the States have an option of providing Medicaid as categorically rather than medically needy. This is completely erroneous. Neither the House bill nor the Senate bill nor the conferees ever discussed the issue of coverage for the optional categorically needy, much less made any decision to eliminate this group. The Committee bill clarifies that the States continue to have the authority to provide coverage, at their option, to any or all of the following optional categorically needy groups: individuals who would be eligible for AFDC if child care costs were paid from earnings (42 C.F.R. section 435.220); individuals under age 21 who would be eligible for AFDC but do not qualify as dependent children (42 C.F.R. sec. 435.222); individuals who would be eligible for AFDC if coverage under the State's AFDC plan were as broad as allowed under Title IV–A (42 C.R.R. sec. 435–223); individuals receiving only optional State supplements (42 C.F.R. sec. 435.230); and individuals in institutions who are eligible under a special income level (42 C.F.R. sec. 435.231).

Section 106(e)(2) of the Committee bill clarifies the treatment of income and resource standards and methodologies for the medically needy. The 1981 Reconciliation Act gave the States certain specified flexibility in designing their medically needy programs. They are no longer required to cover all eligibility groups, e.g., aged, blind, or disabled persons and families with dependent children. They are no longer required to provide the same benefit package to each group they choose to cover. However, the 1981 Reconciliation Act made no changes in the applicable income and resource eligibility rules.

Unfortunately, the Department, in its interim final rule of September 30, 1981, 46 Fed. Reg. 47976, assumed that the conferees had intended to give the States extensive flexibility in this area as well. This is simply incorrect. When the Statement of Managers of the conference committee report spoke of providing the States "with flexibility in establishing eligibility criteria and scope of services within the medically needy program to address the needs of different population groups more appropriately," (H.R. Rep. 97–208, p. 971), it was referring to the service package and coverage group provisions, not inviting a wholesale rewriting of current income and resource standards and methodologies. This amendment makes clear that the Department had no authority to alter the rules that applied before September 30, 1981, with respect to medically needy income levels, medically needy resource standards, and the methodology for treating medically needy income and resources. The Committee bill reaffirms the financial requirements previously in effect for the medically needy (42 C.F.R. sec. 435.800–435.845).

Section 106(e)(3) and (4) and (9) of the Committee bill relate to Medicaid coverage of children. The 1981 Reconciliation Act required that, if a State chooses to cover any groups of individuals as medically needy, it must, among other things, extend coverage for ambula-

tory services to children under 18 who, but for income or resources, would be eligible as categorically needy persons. It repealed the requirement that States provide Medicaid coverage to all individuals between 18 and 21 who are receiving AFDC. It also allowed the States, at their option, to extend Medicaid coverage to individuals aged 18 to 21 who would be eligible for Aid to Families with Dependent Children except for a school attendance requirement, or to any reasonable category of such individuals between 18 and 21. In its interim final rule of September 30, 1981, the Department construed these amendments to permit States to limit medically needy coverage to any reasonable classification of individuals under 18 (46 Fed. Reg. 47981–47982). This erroneous interpretation was upheld by a U.S. District Court who was also misled by this unfortunate drafting errod. *Stacey et al.* v. *Schweiker*, No. 81–2974 (D.D.C., May 21, 1982). This construction is inconsistent with the intent of the Conferees. The Committee bill clarifies that States, if they offer medically needy coverage to anyone, must cover all individuals under 18 who (but for income and resources) would be eligible for Medicaid as categorically needy or optional categorically needy persons. A State may, at its option, offer Medicaid to individuals between 18 and 21 years old or any reasonable category of 18 to 20 years olds.

The Committee bill also strikes any reference to age requirements for dependent children under 19. Since the States must provide Medicaid to all individuals under 19 who receive AFDC assistance as dependent children, and since States are not authorized to limit coverage to medically needy children or optional categorically needy children under 19 on the basis of age, the language that was inserted by section 2172(a) of the 1981 Reconciliation Act is redundant and unnecessary. The bill further clarifies the intention of the conferees not to disturb the previous treatment of individuals under age 21 who would be eligible for AFDC, and therefore Medicaid, except that they are not "dependent," e.g., live in a 2-parent family. Finally, Section 106(e)(1) of the bill also makes clear that these so-called "Ribicoff" children remain an optional categorically needy group; that the States may continue to limit coverage to "reasonable categories" of such individuals if they so choose, as permitted by 42 C.F.R. sec. 435.222 (as it existed before September 30, 1981); and that coverage of this group would not satisfy the State's obligation under its medically needy program to extend coverage to all children under 18 who (but for income or resources) would be covered as categorically needy or optional categorically needy.

Section 196(e)(9) of the Committee bill clarifies the treatment of Medicaid payments to Indian Health Service facilities. The 1981 Reconciliation Act provided for a percentage reduction in Federal Medicaid matching payments to the States, subject to certain offsets. The percentage reductions are to apply to the amounts which States would otherwise be entitled to receive in matching payments in a given quarter. The Conferees inadvertently neglected to exclude payments for claims relating to the provision of Medicaid services through an Indian Health Service facility. The Committee bill clarifies that it was never the intent of the Conferees to subject State Medicaid payments to IHS hospitals and clinics to a reduction in Federal matching rate from the current 100% level.

Section 106(e)(9) of the Committee bill also clarifies the amounts States may claim toward the 1 percentage points penalty reduction for fraud and abuse activities. Under the 1981 Reconciliation Act, States may receive a reduction in their matching payment penalty if their total party and fraud abuse recoveries equal or exceed one percent of Federal matching payments. Fraud and abuse recoveries are defined as amounts that the State demonstrates to the Secretary have been "recovered or diverted" as a result of fraud and abuse control activities, including the operation of the State Medicaid fraud control unit. In interim final regulations, the Department excluded from the definition of "diverted funds" amounts estimated by the States as future savings based on the conviction or suspension of a provider from Medicaid because of fraud or abusive practices. 46 *Fed. Reg.* 48002 (Sept. 30, 1981). There is no reason to deny the States credit towards the fraud and abuse offset for Medicaid funds that are not paid out because the States have suspended or terminated fraudulent providers before they can submit more bogus claims. Nor was it ever the intent of the Conferees to do so, for this would only give States an incentive to keep fraudulent providers on the program so that they could recover funds from them in order to qualify for the 1% offset. Accordingly, the Committee bill clarifies that the "diversion" of funds includes amounts that the States document, to the satisfaction of the Secretary, have been saved by reason of the suspension or termination of a provider for fraud or abuse (but for no longer than a 1 year period). In addition, the bill clarifies that, if a State has demonstrated third party and fraud and abuse recoveries in any quarter in excess of 1 percent of Federal matching payments for that quarter, the State may apply that excess to the following quarter or quarters for purposes of determining whether it qualifies for the offset, until the excess has been fully applied.

Section 106(e)(10) of the Committee bill also clarifies the factors to be used in measuring a State's performance against the Mediciad expenditure target. In fiscal year 1982, for example, a State may receive a dollar-for-dollar reduction in the percentage reduction it would otherwise experience for each dollar its Medicaid outlays fall below 109 percent of its 1981 estimate for FY 1982 outlays. Certain items are to be excluded in calculating whether, and to what extent, a State meets its expenditure target. Unfortunately, two factors were inadvertently omitted from the 1981 Reconciliation Act: payments for claims relating to Medicaid services provided by Indian Health Service facilities, and any increases or decreases in Federal matching payments resulting from changes in the Federal medical assistance percentage. Accordingly, this amendment clarifies that the target amount and State expenditures for each of the 3 fiscal years in question are to be determined without regard to any Medicaid payments to IHS hospitals or clinics, and without regard to any increases or decreases in the Federal matching rate since fiscal year 1981.

Section 106(e)(10) of the Committee bill corrects an erroneous statutory reference in the Secretary's new waiver authority at section 1915(b) of the Social Security Act. The language suggests that Secretary may waive the requirements relating to contracting with HMOs and other providers on a prepaid, capitated basis. The 1981 Reconciliation Act gave States extensive flexibility in contracting with pre-

paid providers. It was never the intent of the Conferees to authorize a waiver of these more flexible requirements, particularly those relating to the ceiling on Medicare and Medicaid enrollment in a prepaid health plan, the ability of beneficiaries to disenroll without cause, on one month's notice, and the need for actuarial soundness in the establishment of capitation rates. The Committee bill makes clear that the Secretary's waiver authority does not include the ability to allow States to ignore the minimal protections contained in Section 1903(m) of the Act.

Section 106(e)(20) of the Committee bill relates to the authority of the Secretary to impose civil money penalties on providers found to have submitted fraudulent Medicare or Medicaid claims. The language appearing at section 1128A(a)(2) of the Social Security Act is somewhat ambiguous in its reference to "an agreement between the person and the United States or a State agency." The Committee bill clarifies the intent of the Conferees that imposition of civil money penalties may be triggered by the presentation to any person of a request for payment in violation of an agreement to take assignment under Medicare Part B or the requirement of a State Medicaid plan to accept the State's reimbursement as payment in full. Of course, providers would not be subject to civil money penalties for securing payment from program beneficiaries of any deductibles, coinsurance, or copayments required under Medicare or the State Medicaid plan.

TITLE II—MEDICARE (PART B) SAVINGS

Reimbursement for inpatient radiology and pathology services (section 201)

The Committee bill reduces reimbursement to radiologists and pathologists for services furnished to hospital inpatients from 100 percent to 80 percent of the physicians' reasonable charges.

Under Current law, Medicare Part B generally pays 80 percent of a physician's reasonable charges after the beneficiary has met the $75 deductible. The beneficiary is responsible for the remaining 20 percent coinsurance and, in cases where the physician chooses not to accept assignment of the claim, any amounts billed that exceed reasonable charges. In the case of inpatient services furnished by radiologists and pathologists who accept assignment, Medicare Part B currently pays 100 percent of the reasonable charge.

The Committee bill eliminates this special 100 percent reimbursement rate. Inpatient services furnished by radiologists and pathologists would be reimbursed at 80 percent of reasonable charges, and acceptance of assignment by these physicians would no longer be required. In the Committee's view, there is no justification for special reimbursement treatment of such services.

Limitation on physician fee economic index (section 202)

The Committee bill limits to 4 percent the increase in the economic index for physician prevailing fees effective October 1, 1982, except for those physicians who agree to accept assignment on all of their claims. The bill also postpones the annual update in the prevailing fee index from July 1 to October 1, effective in 1983.

Under current law, Medicare Part B ordinarily pays 80 percent of reasonable charges for a physician's service. Reasonable charges are the lower of (1) the actual charge submitted by the physician for the service; (2) the physician's customary charge for the service, defined as the 50th percentile of the physician's charges for the service in the previous calendar year; and (3) the prevailing charge for the service in the locality, defined as the 75 percentile of the customary charges of all physicians for that service. Customary and prevailing charge screens are updated annually each July 1 based upon charges submitted during the previous calendar year. The annual increase in the prevailing charge cannot exceed the increase in an economic index reflecting the increases in the costs of operating a practice and general earnings levels. On July 1, 1982, the economic index increased by 8.88 percent.

The Committee bill makes three adjustments to the prevailing charge economic index. First, it reduced the 8.88 percent increase in the index that took effect July 1, 1982. to 4 percent, effective October 1, 1982. This 4 percent limitation would not apply to those physicians who agree to accept assignment on all of their claims: these physicians would receive the entire 8.88 percent increase. The Committee believes that, if reductions in physician reimbursement are necessitated by budgetary constraints, they should be structured in such a way as to create incentives for physicians to accept assignment rather than billing the beneficiary for amounts in excess of the reasonable charge. The Committee bill also postpones the annual update in the index from July 1 to October 1, effective with the update currently scheduled for July, 1983.

Payment to health maintenance organizations (section 203)

The Committee bill would authorize reimbursement to Health Maintenance Organizations (HMOs) on a prospective basis at an amount equal to 95 percent of the average Medicare cost per capita for beneficiaries in the HMO's geographic area. If the actual amount of reimbursement exceeds what the HMO would have been reimbursed under its usual rating system, the HMO would be required to provide its Medicare enrollees additional benefits that are actuarially equal to the excess. The Committee bill makes one change in H.R. 3399, the bill previously reported on this subject. Under the Committee bill, the provision would take effect only when the Secretary of Health and Human Services certifies that he is reasonably certain that the methodology for deriving and adjusting the Medicare average cost per capita can assure actuarial equivalence.

Overview

In hearings on H.R. 3398 and H.R. 3399, the Committee found that existing HMO's, in general, are delivering quality health care, restraining increases in health care costs in their areas, and stimulating the development of additional HMO's and other pre-paid health care plans in their areas. The number of HMO's and their enrollment is growing significantly, due in large part to the efforts of the Federal grant and loan program conducted by the Office of Health Maintenance Organizations; and the amount of private investment and development has increased (see section entitled Background for data).

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With regard to Medicare reimbursement of HMO's, the Committee heard convincing testimony that HMO's can provide Medicare benefits for significantly less cost than the fee-for-service sector. Two of the Committee's witnesses are currently conducting demonstrations, under contract with the Department of Health and Human Services, of the risk based reimbursement scheme provided for in this bill. Medicare beneficiaries enrolled with those two HMO's have all or most of their out-of-pocket expenses for medicare covered services paid for by the HMO out of the savings generated by the HMO; and in addition, Medicare saves 5 percent of what it would have cost for the same beneficiaries in the fee-for-service system.

The Committee believes that this bill overcomes the problems of current law, under which only one HMO has entered into a risk contract. It will encourage HMO participation and enrollment by Medicare beneficiaries and will result in substantial savings to Medicare. Most importantly, it will promote the continued growth of HMO's and increase their ability to compete with the fee-for-service system.

The Committee strongly recommends the policy of promoting HMO development. HMO's have tremendous potential for cost containment, while maintaining quality, because they are the *only* health care organizations in the country today which integrate the delivery of health care services with its financing and reimbursement. An HMO contracts with its members to make providers (such as physicians, other health care professionals and hospitals) available to provide services; and it contracts with its providers to provide them. An insurance plan (including Blue Cross and Blue Shield) contracts with its insureds or members to reimburse them or pay their provider for services if the insured or member finds the provider; its relationship with providers is an agreement to make payments for services provided. The relationship between the HMO and its providers enables, it, through its organizational structure or through financial incentives or risks, to control utilization (particularly inpatient hospital care) and thus costs. While insurance plans can and have taken many steps to reduce utilization, their "fee-for-service" relationship with providers does not permit them to implement the same kind of utilization controls. The result is that their costs, for the same services, are generally higher.

Reimbursement of HMO's by medicare

The Committee's bill would provide reimbursement for health maintenance organizations on the basis of a prospectively determined per capita amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries outside the HMO. Any difference between the HMO's adjusted community rate (adjusted for the higher utilization of the elderly and disabled) and the medicare reimbursement would be returned to medicare beneficiaries in additional benefits.

Under present law, health maintenance organizations may contract for medicare reimbursement on either a cost or risk basis. However, only one HMO has opted to be reimbursed under the existing risk formula. HMO's have generally found the risk reimbursement formula unacceptable because retroactive adjustments are made which take into account the costs actually incurred by the HMO. The new risk formula would provide a prospectively determined per capita payment for each enrollee. The Committee recognizes that HMO's in the

non-medicare portion of their business, receive a fixed, prospectively determined payment per enrollee which is not related to the amount of care. This payment per enrollee acts as a limit on HMO revenues, creating financial incentives for the organization to control costs and to provide the least expensive service appropriate to the enrollee's needs. These incentives are passed on to the physician by paying him on a salary basis, providing a bonus or profit sharing arrangement when costs are kept low, or providing other meaningful incentives for him to control costs and utilization.

Under the Committee's bill, the rates of medicare payment under the risk contract would be set at 95 percent of the per capita amount that would be paid by medicare for services provided to an enrolled beneficiary (classified by actuarial factors such as age) by other providers in the geographic area of the HMO. For example, the rate of payment for a 65 year old beneficiary would be lower than the rate for an 85 year old beneficiary.

The Committee recognizes that the Secretary needs broad discretion in selecting actuarial factors which are appropriate for this purpose. The Committee, therefore, amended the proposed section 1876(a)(3) by adding the phrase "and such other factors as the Secretary determines to be appropriate". However, the Committee expects that the Secretary will carefully evaluate the validity of every factor he proposes to use. It is intended that eligibility for cash benefits under the Disability Insurance program or under SSI may be used as an indicator of disability status if the Secretary deems it appropriate. Since the Committee was particularly concerned about the use of "sex" as an actuarial factor, the Committee also deleted the word "sex" from the same proposed section to make clear that the bill does not require using "sex" as an actuarial factor. In any event the use of any actuarial factor pursuant to such proposed section does not and should not affect in any way the benefits or the out-of-pocket expenses (deductibles and co-insurance) of medicare beneficiaries or their opportunity to enroll in an HMO.

The second important feature of the bill's risk reimbursement formula requires the HMO to provide to enrolled medicare beneficiaries increased benefits or reduced cost-sharing, to the extent that the medicare reimbursement exceeds the HMO's adjusted community rate. This approach would create incentives for medicare beneficiaries to enroll in HMO's and assure that the economies realized through HMO efficiencies, in excess of the HMO's usual profit and other retained funds, accrue to beneficiaries. The HMO would determine that additional benefits, reduced beneficiary cost sharing or combination of the two are most appropriate for its medicare enrollees. The Secretary would be required to report to the Congress three years after enactment on the type and amount of additional benefits which are being provided. The Committee's bill also requires the Secretary to study and report to the Congress the causes for beneficiary disenrollment from HMO's under medicare contracts, paying particular attention to the utilization and quality of services provided these beneficiaries and their medical condition prior to disenrollment.

If an HMO with an existing cost based reimbursement contract elects to enter into a new risk-based contract, the medicare beneficiaries enrolled with the HMO at the time the new contract first applies would

have an option. They could continue to receive their medical care either inside or outside the HMO and be reimbursed by medicare in the current manner; or they could receive services furnished only by or through the HMO (be "locked-in") and have the HMO receive all payments through the new risk contract. The advantage to them of being locked-in is that they could then receive the additional benefits offered by the HMO when its adjusted community rate is less than its payment from medicare. If the Secretary found there were administrative costs or other administrative burdens involved in allowing the HMO to be reimbursed under both cost and risk contracts, he could require all medicare enrollees to be locked-in.

If the HMO had the cost based reimbursement contract on the date of enactment of this bill, then the HMO would be limited in the number of those medicare beneficiaries who were enrolled at the date of enactment who could be reimbursed under the risk contract. One of those enrollees could be included in the risk contract for each two medicare beneficiaries who enroll after the HMO enters into the risk contract. This limitation on medicare beneficiaries participating in the risk contract would apply only to those beneficiaries who are enrolled with the HMO on the date of enactment of this bill. This conversion formula was included to reduce the increase in outlays to medicare due to the new risk reimbursement.

To mitigate the adverse effect on those Medicare enrollees who wish to participate in the risk contract and receive the additional benefits, but cannot because of the conversion formula, an HMO would be allowed to receive cost based reimbursement for them but share with them the additional benefits accruing to Medicare enrollees under the risk contract. If they elected to receive additional benefits they would be locked in.

There are some medicare beneficiaries currently locked into HMO's. They are enrolled in the one current risk contract or are participating in one of the several demonstrations of risk based systems. To protect them, the Committee's bill would delay the mandatory application of the new risk based contract requirements on those HMO's for five years or until the demonstrations are completed. At that time those HMO's would have to choose between cost based or the new risk based reimbursement. If they selected risk, all Medicare beneficiaries enrolled under the old risk contract or the demonstrations could enroll under the new risk contract and the conversion formula would not apply.

An HMO would be defined as a public or private organization which is organized under the laws of any state. It would include both federally qualified HMO's and other HMO's which are constituted in accordance with requirements spelled out in the bill. The Committee carefully developed these requirements so that HMO's which are not federally qualified would be eligible to participate in this new Medicare reimbursement system.

In some parts of the country HMO's have developed without the advantages of being federally qualified. If they realize their potential for operating in a cost efficient manner, they will exert strong competitive pressure on health insurance plans (and thus fee for service providers) to reduce the cost of health services and expand the services offered in their benefit plans. It is the Committee's view that these

HMO's are capable of serving medicare beneficiaries as well as any other health care providers. It would be inappropriate and unnecessary to require these HMO's to become federally qualified in order to participate in this new medicare reimbursement scheme as long as there are assurances that their medicare and other enrollees are satisfied with the care they receive.

An HMO which is not federally qualified must meet five requirements. First, the organization must provide the following comprehensive range of health care services to enrolled members: physicians services, inpatient hospital services, laboratory, X-ray, emergency and preventive services and out of area coverage. Preventive health services would include services such as voluntary family planning, well child care, periodic health evaluation for adults and pediatric and adult immunizations.

Second, the organization must be compensated (except for deductibles, co-insurance and co-payments) for the provision of health care services to a member by a fixed periodic payment which is unrelated to the frequency, extent, or kind of health care services actually provided to that member.

Third, the organization must provide physician services either (1) directly through physicians who are either employees or partners of the organization, or (2) through contracts with individual physicians or one or more groups of physicians organized on a group practice or individual practice basis.

One of the most important features which distinguishes an HMO from a health insurance plan is that an HMO contracts with its members to make physicians available to them to provide necessary services while an insurance plan contracts with its insureds to pay for physicians' services if the insured individuals locate the physicians. If the HMO does not have contracts with its physicians it could not assure its members of the availability and accessibility of their physicians.

Fourth, the organization must assume full financial risk on a prospective basis for the provision of its health care services. Exceptions to this requirement are that the organization may (1) obtain insurance or make other arrangements for the cost of providing health care services to any one enrollee in excess of $5,000 a year, for the cost of out-of-area medically necessary services, and for up to 90 percent of the amount by which its costs for any fiscal year exceed 115 percent of its income for that year; and (2) share all or part of the risk for the provision of services to members with the physicians, other health care professionals, hospitals, and other institutions which provide those services to members. The assumption of financial risk on a prospective basis is an essential characteristic of an HMO. Because an HMO provides services within a fixed annual budget it constantly seeks to control its costs. It is the Committee's view that an HMO cannot contain its costs if it does not promote efficient utilization of services and facilities by its physicians and other health care providers. The Committee intends for HMO's to use mechanisms, such as risk sharing, financial incentives or other incentives, with their physicians to encourage them to monitor utilization, achieve utilization goals and thereby control costs.

And fifth, the organization must make adequate provision against the risk of insolvency. Without this requirement individuals enrolled

could be subject to the unexpected bankruptcy of their HMO and subsequent disruption of their health care services.

If an organization meets these five requirements it would be considered a health maintenance organization for purposes of reimbursement under medicare. In order to participate in medicare, however, it must also meet for its medicare beneficiaries certain conditions of participation. (Federally qualified HMO's must also meet these conditions.)

There are eight conditions of participation. First, the HMO's minimum benefit package must include the services to which a medicare beneficiary is entitled. It may include additional health care services at the option of the medicare beneficiary or if the Secretary approves such additional services. The purpose of permitting Secretarial approval of a broader minimum benefit package is to allow an HMO to offer Medicare beneficiaries the same minimum benefit package offered non-Medicare enrollees. (The HMO could add services to those approved by the Secretary only at the election of the Medicare beneficiaries.) If the Secretary determined that including additional services would substantially discourage enrollment by Medicare beneficiaries, then the Secretary would not approve the addition. Under any circumstance the HMO is required to inform medicare beneficiaries of the portion of their premium rate or other charges which are applicable to any additional services.

Second, the HMO must limit the amount of premium or other payments charged to its medicare enrollees for their entitled benefits to the actuarial equivalent of medicare deductibles and coinsurance that would apply to these beneficiaries were they not enrolled in the HMO. Any premium charged and the actuarial value of any deductible, coinsurance or co-payment charged for additional services (described in the preceding paragraph) could not exceed the adjusted community rate for those services.

Third, the HMO must provide services to medicare beneficiaries through institutions, entities and persons meeting the applicable requirements of Sec. 1861 of the Social Security Act.

Fourth, in order to assure that an HMO makes a genuine effort to enroll medicare beneficiaries, the HMO must have an open enrollment period of reasonable duration at least every year during which it accepts medicare beneficiaries up to the limits of its capacity and without restrictions in the order in which they apply for enrollment. This requirement is necessary since most HMO's enroll only groups and medicare beneficiaries, in many instances, would be enrolling as individuals. Without assurance of open enrollment, such medicare beneficiaries would have no access to the HMO. No HMO, however, would have to accept proportionately more medicare enrollees than are represented in the population in the geographic area served by the HMO.

Fifth, the HMO must (1) provide assurances to the Secretary that it will not expel or refuse to re-enroll any medicare individual because of that individual's health status or requirement for health care services, and (2) notify each medicare beneficiary of such fact at the time of the individual's enrollment.

Six, the HMO must make its services available and accessible to medicare beneficiaries within the area served by the HMO promptly and in a manner which assures continuity. When medically necessary,

those services must be available and accessible 24 hours a day and seven days a week. The HMO must also reimburse a medicare beneficiary if he or she paid for medically necessary and immediately required health care services rendered outside the HMO's service area.

Seventh, the HMO must provide meaningful procedures for hearing and resolving grievances between the HMO (including any entity or individual through which it provides its health services) and medicare beneficiaries.

And eighth, the HMO must have arrangements, established in accordance with regulations of the Secretary, for an on-going quality assurance program for health care services it provides to medicare beneficiaries.

Because federally qualified HMO's and other HMO's will participate in this medicare program, the committee intends for the Office of Health Maintenance Organizations in the Department of Health and Human Services to play a major role in determining whether an organization seeking participation under this provision meets the HMO definition and complies with the conditions of participation. Since many of the conditions of participation are similar to requirements for federally qualified HMO's, those conditions should be interpreted consistently with the requirements of Title XIII of the Public Health Service Act.

Federally qualified HMO's must set their premiums under a "community rating system" which is defined in Section 1302(8) of the Public Health Service Act. Because the Committee expands the definition of HMO's to include organizations not federally qualified, the Committee's bill permit an HMO to develop an adjusted community rate for its medicare beneficiaries based upon its weighted aggregate premium for non-medicare beneficiaries. The adjustment of the weighted aggregate premium would be made in a manner similar to the adjustment of the community rate of a federally qualified HMO.

To insure that non-federally qualified HMO's which meet the definition of the Committee's bill disclose their ownership and related information in accordance with section 1124 of the Social Security Act, the Committee's bill modifies the definition of HMO's in Section 1124 so that it includes HMO's as defined in the Committee's bill.

During the Committee's deliberation some concern was expressed that HMO's will unduly benefit from participation in this program. It is the Committee's view that HMO's will benefit because this new system of reimbursement for medicare beneficiaries is consistent with their mode of operation for their other enrollees. An HMO will be paid an amount equal to 95 percent of the cost of providing medicare benefits to beneficiaries in its area, but the HMO will retain only that portion of the amount equal to its adjusted community rate. The difference will be returned to its medicare beneficiaries. An HMO will be required to conduct an open enrollment period during which it must accept medicare beneficiaries in the order in which they apply for enrollment. Because medicare beneficiaries are older they require considerably more health services; so an HMO will be assuming substantial financial risk during this open enrollment period.

Concerns were also expressed to the Committee that because non-federally qualified HMO's will be permitted to participate medicare beneficiaries will be subjected to significant abuses by unregulated

HMO's. The Committee also believes that this concern is unfounded. If a medicare beneficiary believes that he or she has received inadequate services or determines that he or she does not want to continue enrollment for any reason, they may terminate enrollment with one month's notice. In addition, an HMO's medicare and medicaid enrollment cannot exceed 75 percent of its total enrollment. This provision, more than any other, will assure that participating HMO's are stable, well managed community businesses. If they do not satisfy the health care needs of their non-medicare enrollees, so that they disenroll and their number decline below one-quarter of the total enrollment, the HMO cannot continue participating in this medicare program.

The Committee's bill would permit an HMO to select reimbursement on either a risk basis, as established by the bill, or a cost basis as currently provided in section 1876.

Under the bill, the new HMO provisions may not be implemented until the Secretary of Health and Human Services notifies the Congress that he is reasonably certain that the methodology to make appropriate adjustments in the average adjusted per capita cost (AAPCC) has been developed and can be implemented to assure actuarial equivalence. With such methodology savings are expected to accrue to the Medicare program for each new Medicare beneficiary who enrolls in an HMO.

Many Federal agencies and departments collect and maintain health status and medical care utilization information that could be important to the Secretary of the Department of Health and Human Services in the development of an AAPCC. It is the intent of the Committee that the Secretary work with federal departments and agencies, including the Department of Labor, the Office of Personnel Management, the Veterans Administration, and the Social Security Administration, in gathering the necessary data.

Medicare enrollment provisions for merchant seamen and special general enrollment period (section 204)

The Committee bill waives the late enrollment penalty under Medicare Part B for merchant seamen and other individuals who enroll during a special enrollment period.

Under current law, individuals who voluntarily choose to enroll in the Supplementary Medical Insurance (Part B) portion of the Medicare program may enroll during one of two periods: (1) their initial enrollment period, which is based on the date when such individuals meet the eligibility requirements for enrollment, or (2) a general enrollment period, during which persons who failed to enroll during their initial period or whose enrollment has been terminated, may first enroll or re-enroll. Individuals who elect to enroll after their initial opportunity to do so, or who re-enroll after a termination of coverage, are required (with certain minor exceptions) to pay increased monthly premiums for delinquent enrollment of 10 percent for each 12 months of delay in enrollment or re-enrollment.

The 1981 Omnibus Budget Reconciliation Act terminated the entitlement to free care for merchant seamen and mandated the closure or transfer of the Public Health Service Hospitals and Clinics from which these beneficiaries received care. A number of seamen, relying on the Federal Government's commitment to provide for their medical

needs, did not enroll in Medicare even though eligible to do so. With the elimination of the entitlement and the closure of the PHS Hospitals and Clinics, these individuals were left without health coverage. Under these circumstances, it seems to the Committee inequitable to impose a late enrollment penalty upon these seamen.

Accordingly, the Committee bill establishes a special enrollment period under Medicare Part B for merchant seamen who were eligible to enroll in Medicare Part A and B before September 30, 1981, and who were entitled to free medical benefits under the Public Health Service Act from March 10, 1981 until October 1, 1981, when the entitlement ended. The special enrollment period would begin on the first day of the first month beginning at least 20 days after enactment. Coverage would begin on the first day of the month following the month that the individual applies or, at the individual's option, October 1, 1981. If the individual elects to make coverage retroactive to October 1, 1981, he would be responsible for monthly premiums for the months so covered (without any premium penalty).

Any individual who enrolled in Medicare Part A or Part B during this special enrollment period would not be subject to the 10 percent premium penalty for late enrollment for any month for which he can establish that he was entitled to benefits under the PHS Act. Entitlement to PHS Act benefits may be established through hospital or clinic records, seamen's papers, or such other reasonable documentation as the Secretary of Health and Human Services may require. The Committee expects that the Secretary, the program intermediaries, and the former PHS facilities cooperate in expeditiously furnishing the necessary documentation to affected individuals.

The bill directs the Secretary to notify, no later than 60 days after enactment, merchant seamen, unions, SSA district offices, and former PHS hospitals and clinics of the special enrollment period. The conferees expect the Secretary to make all reasonable efforts to assure that merchant seamen are made aware of their benefits under this provision.

The waiver of the premium penalty is not available to merchant seamen who enrolled in Medicare Part B prior to March 10, 1981, unless the enrollment of these individuals was terminated solely because the individual lost eligibility and not for failure to pay the required premiums. The waiver is also not available to any merchant seamen who apply after the close of special enrollment period on December 31, 1982.

It is the Committee's understanding that some of these individuals may have enrolled in Medicare Part B during the regular enrollment period between January 1, 1981, through September 30, 1981, or between January 1, 1982, through March 30, 1982. If such individuals are otherwise qualified for the penalty waiver under this provision, the Committee expects that the Secretary will rebate any premium penalties assessed against such individuals (other than those not waived by this provision) without requiring them to enroll during the special enrollment period.

The Committee bill also extends the opportunity to enroll in Medicare Part B without imposition of the late enrollment penalty to other individuals who are eligible to enroll but have not done so. In order to

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qualify for this waiver, the individual must enroll during a special enrollment period beginning on the first day of the first month that starts at least 20 days after enactment and ends on December 31, 1982. The coverage period for such individuals begins on July 1, 1983. The bill directs the Secretary to disseminate information to SSA offices and the public generally to inform individuals of this special enrollment period. The waiver of the later enrollment penalty does not apply to individuals who have previously enrolled in Medicare Part A or Part B, unless the individual's enrollment was involuntarily terminated due to loss of eligibility.

III. Hearings

The Committee's Subcommittee on Health and the Environment held one day of hearings on Medicaid and Medicare Part B changes assumed by the First Concurrent Budget Resolution on July 16, 1982. Testimony was received from 10 witnesses, representing 10 organizations, with additional material submitted by 2 individuals and organizations.

IV. Committee Consideration

On July 28, 1982, the Committee on Energy and Commerce met in open session and ordered reported the bill H.R. 6877 with amendment by voice vote, a quorum being present.

V. Committee Oversight Findings

Pursuant to clause 2(l)(3)(A) of rule XI of the rules of the House of Representatives, the Subcommittee on Health and the Environment, in conjunction with the Subcommittee on Oversight and the Subcommittee on Public Assistance and Unemployment Compensation of the Committee on Ways and Means, conducted a joint oversight hearing on the impact of program changes and budget cuts in AFDC, Medicaid, and Social Services programs in Memphis, Tennessee, on November 9, 1981. The findings are reflected in the legislation report.

The Committee notes that additional oversight hearings have been conducted by the Subcommittee on Oversight and Investigations of this Committee.

VI. Committee on Government Operations

No oversight findings or recommendations have been submitted to the Committee by the House Committee on Government Operations with respect to the subject matter contained in the bill.

VII. Committee Cost Estimate

In compliance with clause 7(a) of rule XIII of the rules of the House of Representatives, the Committee believes that the savings incurred in carrying out H.R. 6877 would be $542 million in FY 1983, $747 million in FY 1984, and $857 million in FY 1985.

VIII. Congressional Budget Office Estimate

U.S. Congress,
Congressional Budget Office,
Washington, D.C., August 2, 1982.

Hon. John D. Dingell,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, D.C.

Dear Mr. Chairman: Pursuant to Section 403 of the Congressional Budget Act of 1974, the Congressional Budget Office has prepared the attached cost estimate for H.R. 6877, the Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982, as ordered reported by the House Committee on Energy and Commerce on July 28, 1982.

Should the Committee so desire, we would be pleased to provide further details on this estimate.

Sincerely,

Raymond C. Scheppach
(For Alice M. Rivlin, Director).

CONGRESSIONAL BUDGET OFFICE—COST ESTIMATE

August 2, 1982.

1. Bill number: H.R. 6877.

2. Bill title: Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982.

3. Bill status: As ordered reported by the House Committee on Energy and Commerce on July 28, 1982.

4. Bill purpose: To bring expenditures authorized by the House Committee on Energy and Commerce within the reconciliation target for that Committee established by the Congress.

5. Cost estimate: Table 1 shows the budget authority (BA) and outlay (O) effects of the bill. Details are shown in subsequent tables. Some sections in this bill would reduce future federal liabilities through changes to existing entitlements and therefore could permit subsequent appropriations actions to reduce the budget authority for these programs. For such sections, the figures shown as BA represent those amounts by which budget authority could be reduced, as a result of this bill, below the levels needed under current law. The budgetary effects of this bill fall within function 550.

TABLE 1.—SUMMARY OF BUDGETARY EFFECTS OF H.R. 6877

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
A. Direct spending reductions	BA	−51	−300	−376	−426	−497	−554
	O		−560	−770	−896	−1,039	−1,175
B. Direct spending increases	BA	4	14	23	39	40	34
	O		18	23	39	40	34
C. Total direct spending changes	BA	−47	−286	−353	−387	−457	−520
	O		−542	−747	−857	−999	−1,141

TABLE 1A.—DETAILS OF DIRECT SPENDING REDUCTIONS IN H.R. 6877

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
MEDICAID							
Allow States to require copayments on certain services (Sec. 101).	BA	−11	−34	−50	−56	−62	−68
	O	----------	−45	−50	−56	−62	−68
Allow States to apply liens (Sec. 102)	BA	−40	−125	−180	−200	−217	−237
	O	----------	−165	−180	−200	−217	−237
Allow States to provide medicaid coverage for disabled children at home (Sec. 105).	BA	----------	----------	----------	----------	----------	----------
	O	----------	----------	----------	----------	----------	----------
Impact of proposed medicaid legislation on current law penalties.	BA	----------	----------	20	20	----------	----------
	O	----------	----------	20	20	----------	----------
Total, Medicaid	BA	−51	−159	−210	−236	−279	−305
	O	----------	−210	−210	−236	−279	−305
MEDICARE							
Reduce reimbursement for radiology and pathology services—SMI (Sec. 201).	BA	----------	−53	−63	−70	−80	−91
	O	----------	−160	−210	−250	−280	−320
Limitation on economic index—SMI (Sec. 202)	BA	----------	−88	−103	−120	−138	−158
	O	----------	−190	−350	−410	−480	−550
Medicare payments of HMO's (Sec. 203)	BA	----------	(1)	(1)	(1)	(1)	(1)
	O	----------	(1)	(1)	(1)	(1)	(1)
Total, Medicare	BA	----------	−141	−166	−190	−218	−249
	O	----------	−350	−560	−660	−760	−870

[1] Budgetary effect cannot be estimated because implementation depends on development by the administration of a methodology that would be intended to assure actuarial equivalence in the age adjusted per capita cost. Once implemented, the provision would have relatively small costs or savings depending on the success of the methodology to be developed.

TABLE 1B.—DETAILS OF DIRECT SPENDING INCREASES IN H.R. 6877

[By fiscal year, in millions of dollars]

		1982	1983	1984	1985	1986	1987
MEDICAID							
Provide offsets to States for lower hospital costs (Sec. 103).	BA	----------	----------	----------	11	12	----------
	O	----------	----------	----------	11	12	----------
Allow States to continue medicaid eligibility for certain individuals (Sec. 105).	BA	----------	1	1	1	1	2
	O	----------	1	1	1	1	2
Reduce reimbursement for radiology and pathology services in medicare.	BA	4	11	15	20	20	25
	O	----------	15	15	20	20	25
Total, medicaid	BA	4	12	16	32	33	27
	O	----------	16	16	32	33	27
MEDICARE							
Special SMI enrollment period—offsetting receipts (Sec. 204).	BA	----------	2	7	7	7	7
	O	----------	2	7	7	7	7

6. Basis of estimate: The budget authority and outlay estimates have been determined by CBO staff and are based on data from the Administration and other sources.

One of the proposed changes in Medicare would cause outlays in Medicaid to change. Reducing reimbursemnt for radiology and pathology services in Medicare would shift some of the costs for these services to the Medicaid program. This change in outlays is reflected in the cost estimate tables.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Hinda Ripps Chaikind, Malcolm Curtis, Lisa Potetz.

10. Estimate approved by:

C. G. Nuckols,
(For James L. Blum,
Assistant Director for Budget Analysis).

IX. Inflationary Impact Statement

Pursuant to clause 2(1)(4) of rule XI of the rules of the House of Representatives, the Committee makes the following statement with regard to the inflationary impact of the reported bill:

The Committee concludes that the changes made in existing law by this bill will not have an inflationary impact on prices and costs in the operation of the national economy.

X. Section-by-Section Analysis

SECTION 1

The first section contains the short title of the bill, "Medicaid and Medicare Part B Budget Reconciliation Amendments of 1982."

SECTION 101. PERMITTING NOMINAL COPAYMENTS FOR MOST SERVICES

Section 101(a)(1) of the bill amends section 1902(a)(14)(A) of the Social Security Act to allow States to impose certain cost sharing charges and copayments on most health care services furnished to categorically needy Medicaid beneficiaries. States would be precluded from imposing such charges with respect to (1) inpatients in skilled nursing or intermediate care facilities; (2) pregnant women or care and services related to pregnancy (including postpartum services); (3) individuals under 21 and individuals enrolled in health maintenance organizations; or (4) emergency services and family planning services and supplies. Cost sharing charges must be nominal in amount and could not exceed $1 per day for inpatient hospital services or $1 per visit for outpatient hospital services, physicians' services, and clinic services. The State may impose a charge of $4 per visit for services received at an emergency room of a hospital if the services are not emergency services and the State has established that alternative sources of nonemergency, outpatient services are available and accessible.

Section 101(a)(2) also amends section 1902(a)(14)(B) to provide that no cost sharing charges be imposed on medically needy Medicaid beneficiaries for (1) services furnished to pregnant women or related to pregnancy; (2) services furnished to individuals under 21; or (3) services which are emergency services or family planning services and supplies. This section further provides that cost sharing charges imposed on medically need beneficiaries be nominal in amount, except that a charge of up to $4 per visit may be imposed for the services received at an emergency room of a hospital if the services are not emergency services and the State has established that alternative sources of nonemergency outpatient services are available and accessible.

Section 101(b) further amends section 1902(a)(14) of the Social Security Act to provide that no provider participating under a State's Medicaid plan may deny care or services to beneficiaries because of inability to pay cost-sharing charges.

Section 101(c) amends section 1902(a)(10) to provide that the imposition of cost sharing charges for any item or service furnished to an individual not eligible for exemption as specified under

amended section 1902(a)(14)(A)(ii) or (14)(B)(ii) shall not require the States to impose cost-sharing charges for the same item or service furnished to individuals eligible for exemption.

Section 101(d) provides that the amendments permitting nominal copayments under Medicaid for most services, with certain exceptions, be effective for calendar quarters beginning on or after October 1, 1982. For State Medicaid plans which require State legislation in order to meet the requirements imposed by these amendments, these plans will not be regarded as failing to comply before the first day of the first calendar year beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of the amendments.

SECTION 102. RECOVERY OF COSTS AND DISPOSAL OF HOME IN THE CASE OF INSTITUTIONALIZED MEDICAID RECIPIENTS

Section 102(a) rewrites paragraph 18 of section 1902(a) to provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State's Medicaid plan, except (1) pursuant to the judgment of a court that benefits were incorrectly paid on behalf of the individual, or (2) in the case of the real property of an individual who is an inpatient in a skilled nursing or intermediate care facility and whom the State establishes, after notice and opportunity for a hearing, is reasonably likely to remain in the facility as an inpatient for the remainder of his life. If this latter individual is subsequently discharged from the facility and returns home, the lien imposed would dissolve.

The amended paragraph 18 would also provide that there would be no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State's Medicaid plan, except under certain circumstances, and then only after the death of a surviving spouse, if any, and only at a time when there is no surviving child who is under 21 or blind or permanently and totally disabled (as defined under the Supplemental Security Income program) or blind or disabled (as defined under the State program established under title XVI) or, in the case of a lien on the individual's home, only at a time when no sibling, son, or daughter of the individual (who was residing in the individual's home for a period of at least one year immediately before the date of admission to a facility) is lawfully residing in the home.

Adjustment or recoveries could be made in the case of an individual who was 65 or over when he received Medicare assistance or with respect to property subject to a lien or trust related to such a lien from such individual's estate or trust upon his death. In the case of property which is subject to a lien and which has been sold, the proceeds must be put into a trust. If the lien (with respect to which the trust was established) would otherwise have been dissolved because of the individual's discharge from a facility, the trust shall be terminated and the corpus revert to the individual. The Secretary shall provide terms for such a trust, including permitting the income to be used for the reasonable care and maintenance of a spouse and children under age 21 or without an age limit if under a disability.

Section 102(b) amends section 1902(j) by adding a new subparagraph to provide that States may deny Medicaid eligibility to an individual who has been determined to be reasonably likely to remain in a skilled nursing or intermediate care facility for the remainder of his life and who at any time during or after the twenty-fourth month prior to the month in which the individual applied for assistance under the State's Medicaid plan, disposed of a home for less than its fair market value. However, an individual could not be denied eligibility if: (1) title to the home were transferred to the individual's spouse or child who is under 21 or (with respect to States eligible to participate under SSI) is blind or permanently and totally disabled or (with respect to States not eligible to participate in SSI) is blind or disabled as defined in section 1614 of the Act; (2) the individual demonstrates to the satisfaction of the State that he intended to dispose of the home either at fair market value or for other valuable consideration, or (3) the State determines that denial of eligibility would work an undue hardship. The period of ineligibility imposed with respect to services furnished to an individual as an inpatient of a facility and because of the transfer of a home for less than fair market value must be computed in a manner such that the cost of services that would otherwise be made available to the individual during the period bears a reasonable relationship to the amount of the uncompensated value of the home.

Section 102(c) provides that the amendment which would allow States to deny Medicaid eligibility to individuals who are in inpatient skilled nursing or intermediate care facilities and who transfer their homes for less than fair market value would apply to applications for Medicaid assistance filed on or after October 1, 1982.

SECTION 103. STATE FLEXIBILITY IN PROVIDER REIMBURSEMENT

Section 103(a) amends section 1903(s)(3)(A) of the Social Security Act with regard to qualified hospital cost review programs by which States can partially offset reductions in Federal matching payments required by the Omnibus Budget Reconciliation Act of 1981. In order to be eligible for a one percent offset on the basis of a qualified hospital cost review program, States are required to have such programs in effect by July 1, 1981. Section 103(a) deletes this date so as to allow States to qualify for this offset regardless of when they have hospital cost review programs in place.

Section 103(b) adds a new section 1916 to title XIX of the Social Security Act.

New Section 1916(a) provides that States may have the new section 1916 apply in lieu of an offset for qualified hospital cost review programs in all quarters of FY 1983 and FY 1984.

New Section 1916(b) provides that States could qualify for this one percent offset if the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) for calendar year 1983 or 1984 is less than the State target date of increase for that calendar year.

New Section 1916(c)(1) specifies by how much a State's annual rate of increase in aggregate hospital inpatient costs per capita or per

admission would have to be reduced below its target rate in order to qualify for this offset. This section provides that if the State base rate is less than the U.S. base rate the State target rate of increase for that year would be a rate of increase determined under the formula: R x (N−2), where R is the ratio of the State base rate to the U.S. base rate for that year and N is the annual rate of increase in aggregate hospital inpatient costs per capita or per admission in the U.S. for the years involved. If the State base rate is equal to or greater than the U.S. base rate, the State target rate of increase for that State for that year is a rate of increase equal to 2 percentage points less than the annual rate of increase in aggregate hospital inpatient costs per capita or per admission in the U.S. for that year.

New Section 1916(c)(2) defines the term "State base rate" to mean, for a State for calendar year 1983 or calendar year 1984, the annual rate of increase in aggregate hospital inpatient costs per capita or per admission in the State in the three calendar year period preceding such year.

New Section 1916(c)(3) defines the term "United States base rate" to mean, for calendar year 1983 or calendar year 1984, the annual rate of increase in aggregate hospital inpatient costs per capita or per admission in the U.S. in the three calendar year period preceding such year.

SECTION 104. MEDICAID COVERAGE OF HOME CARE FOR CERTAIN DISABLED CHILDREN

Section 104(a) of the bill amends section 1902(e) of the Social Security Act to add a new paragraph giving States the option of deeming, for purposes of Medicaid coverage only, certain disabled children age 18 or under as recipients of SSI or State supplementary payments. A child qualifying under this provision is one who meets the definition of disability under section 1614(a) and with respect to whom the State has determined that: (1) he requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility; (2) it is appropriate to provide such care for the individual outside such an institution; and (3) the estimated amount expended for care in the home is not greater than amounts expended for care within an appropriate institution.

Section 104(b) provides that this amendment would become effective October 1, 1982.

SECTION 105. OPTIONAL MEDICAID COVERAGE FOR CERTAIN DEPENDENT CHILDREN AND RELATIVES WITHOUT REGARD TO CRAIN WORK DISINCENTIVES IMPOSED BY THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981

Section 105 amends section 1902(e) of the Social Security Act to allow States to continue Medicaid coverage for working families who are made ineligible for AFDC as a result of certain changes made by the Reconciliation Act of 1981. This amendment adds a new paragraph (3) to section 1902(e).

New Section 1902(e)(3)(A) provides that a State may treat. for purposes of the State's plan approved under this title, as an individual receiving aid or assistance under the plan of the State approved under

part A of title IV, an individual who would be eligible for such aid or assistance under such plan but for any or all of the limitations or requirements described in subparagraph (B), if the individual meets such alternative requirements as the State may provide for under subparagraph (C).

New Section 1902(e)(3)(B) provides that the limitations and requirements referred to in subparagraph (A) are as follows:

(i) The limitation to $75 in any month in section 402(a)(8)(A)(ii) on the total amount of the disregard from earned income for work expenses.

(ii) The limitation to $160 in any month in section 402(a)(8)(A)(iii) on the total amount of the disregard from earned income for certain child care (and other care) expenses.

(iii) The fact that the earned income disregard contained in section 402(a)(8)(A)(iv) is only computed after the disregards described in clauses (ii) and (iii) of section 402(a)(8)(A) are taken.

(iv) The limitation in section 402(a)(8)(B)(ii) to 4 months on the period for which the disregard described in section 402(a)(8)(A)(iv) can be taken and to 12 consecutive months on the length of the additional minimum period which must expire before such disregard can be taken again.

(v) The provisions of sections 402(d)(1) and 402(a)(17) as they require an earned income advance amount (under section 3507(a) of the Internal Revenue Code of 1954) or a refund of Federal Income tax by reason of the earned income tax credit (under section 43 of the Internal Revenue Code of 1954) to be considered as income for any month other than the month in which the amount or refund is actually received.

(vi) The limitation to 150 percent of the State's need standard under section 402(a)(18) on the total income that families may have and still be eligible for aid under part A of title IV.

New Section 1902(e)(3)(C) provides that with respect to the alternative requirements referred to in subparagraph (A), in lieu of the limitation or requirement referred to in—

(i) Clause (i) of subparagraph (B), the State may provide for a dollar limitation on the disregard in section 402(a)(8)(A)(ii) equal to an amount greater than $75.

(ii) Clause (ii) of subparagraph (B), the State may provide for a dollar limitation on the disregard in section 402(i)(8)(A)(iii) equal to an amount greater than $160.

(iii) Clause (iv) of subparagraph (B), the State may provide that the disregard described in section 402(a)(8)(A)(iv) shall not apply after a period (specified by the State) of longer than the 4 months described in section 402(a)(8)(B)(ii) or may again apply after the expiration of an additional period (specified by the State) of less than the 12 consecutive months described in section 402(a)(8)(B)(ii)(II).

(iv) Clause (v) of subparagraph (B), the State may provide that receipt of a refund of Federal income tax by reason of the earned income tax credit may result in ineligibility for a period (specified by the State) of less than that provided under section 402(a)(17).

(v) Clause (vi) of subparagraph (B), the State may substitute a percentage (greater than 150 percent) for the percent specified in

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section 402(a)(18). Nothing in this paragraph shall be construed as requiring a State to provide for any alternative requirement described in this subparagraph.

SECTION 106. CORRECTIONS REFLECTING TECHNICAL ERRORS IN MEDICAID-RELATED PROVISIONS OF THE OMNIBUS BUDGET RECONCILIATION ACT OF 1981

Section 106 makes various technical and conforming amendments to title XIX, including those to clarify that the States' option to cover the optional categorically needy groups was not eliminated under the Reconciliation Act of 1981; to clarify intent that all categorically related children under 18 must be covered if a State opts to have a medically needy program; to specify that reductions in Federal matching payments do not apply to payments to Indian Health Service facilities or to Medicaid fraud units; to indicate that waiver language does not apply to the new more flexible requirements for HMOs that were included in the Reconciliation Act; and to clarify that the one percent offset to States for fraud and abuse recoveries included amounts saved due to suspension or terminations of providers or other persons.

SECTION 201. REIMBURSEMENT FOR INPATIENT RADIOLOGY AND PATHOLOGY SERVICES

Section 201(a) amends section 1833(a)(1) of the Social Security Act to provide that any expenses incurred for radiological of pathological services furnished to hospital inpatients shall be paid at 80 percent instead of 100 percent of the reasonable charges for such services.

Section 201(b) amends section 1833(b) of the Act to provide that any expenses for radiological or pathological services shall be subject to the annual deductible requirements of the Part B program.

Section 201(c) provides that the amendments made by section 201 shall apply to items and services furnished on or after October 1, 1982.

SECTION 202. LIMITATION OF PHYSICIAN FEE ECONOMIC INDEX

Section 202(a) amends the provisions of section 1842(b) of the Social Security Act to provide that, for physicians' services rendered during the 12-month period ending September 30, 1983, prevailing charge levels shall not exceed 104 percent of the level that was in effect for such services for the 12-month period ending June 30, 1982. For subsequent periods, the Secretary will treat the level set during such 12-month period as fully providing for the economic change which would otherwise be taken into account in setting such levels during such period. Such limitation would not apply to the services of any physician who has in effect (for a 12-month period ending on September 30) an agreement with the Secretary to accept assignments for all physicians' service furnished by him to individuals enrolled in Part B.

Section 202(b) provides that the amendments made by section 202 shall apply to items and services furnished on or after October 1, 1982.

SECTION 203. PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

Section 203(a) amends section 1876 of the Social Security Act as follows:

New Section 1876(a)(1) requires that every year, the Secretary would determine a per capita rate of payment for each class of individuals who are enrolled with an HMO (as defined in subsection (b)(1)) and who are covered by either parts A and B, or part B only, of Medicare. The payment rate would be equal to 95 percent of the "adjusted average per capita cost" for each class.

New Section 1876(a)(2) defines the "adjusted average per capita cost" as the per capita amount the Secretary estimates would be paid for services provided to Medicare beneficiaries by other providers (physicians, hospitals, etc.) in the geographic area of the HMO.

New Section 1876(a)(3) provides that, in establishing the classes of individuals for purposes of subsection (a)(1), the Secretary must take into consideration such factors as age, institutional and disability status, place of residence and other appropriate factors.

New Section 1876(a)(4) provides that the Secretary would make monthly payments, in advance, to the HMO for each enrolled Medicare beneficiary.

New Section 1876(a)(5) provides that the payment to an HMO for Medicare beneficiaries would be made from the Federal Hospitalization Insurance Trust Fund (part A) and the Federal Supplementary Medical Insurance Trust Fund (part B) according to specified proportions.

New Section 1876(b)(1) defines a "health maintenance organization" as a public or private organization, organized under State law, which either (a) is a qualified HMO as defined in section 1310(d) of the Public Health Service Act, or (b) provides certain services including physicians', inpatient hospital, laboratory, X-ray, emergency and preventive, and out-of-area coverage; is compensated on a prepaid basis; provides physicians' services through employees, partners, or under contract; assumes full financial risk on a prospective basis for all covered health care services (four exceptions are permitted); and makes adequate provision against the risk of insolvency.

New Section 1876(b)(2) provides that, in addition to meeting the definition of (b)(1), the HMO must also comply with several conditions of participation:

(1) The HMO must provide to Medicare beneficiaries those services included in parts A and B of Medicare and could provide any additional health care services approved by the Secretary or elected by the beneficiary.

(2) Copayments for the provision of part A and B services to Medicare beneficiaries could not exceed the limits described in subsection (g).

(3) The HMO must provide all part A and B services to Medicare beneficiaries through institutions, entities and persons which meet the requirements of title XVIII and part A of title XI of the Social Security Act.

(4) The HMO must have an annual open enrollment period for Medicare beneficiaries which is of reasonable duration and during

which it accepts beneficiaries up to the limits of its capacity and without restrictions (except per regulation), in the order in which they apply, unless to do so would result in more Medicare beneficiaries than are permitted by subsection (h) or an enrollment unrepresentative of the population in the geographic area of the HMO.

(5) The HMO could not expel or refuse to reenroll any Medicare beneficiary because of health status or requirements for health services and must notify each beneficiary of such fact at enrollment.

(6) Required services must be available and accessible to Medicare beneficiaries and, when medically necesary, on a 24-hour a day, seven day a week basis, and reimbursement must be provided for medically necessary services received from a provider other than the HMO.

(7) The HMO must provide a meaningful grievance procedure for Medicare beneficiaries.

(8) The HMO must have an ongoing quality assurance program for health services provided to Medicare beneficiaries.

New Section 1876(c) provides that the HMO would be paid directly; the Medicare beneficiary would receive no payments.

New Section 1876(d) provides that every Medicare beneficiary covered by parts A and B, or part B only, (except those individuals with end-stage renal disease) could enroll with any participating HMO in their area.

New Section 1876(e) provides that Medicare beneficiaries enrolled with the HMO may terminate their enrollment at the beginning of the first calendar month following a full calendar month after the termination is requested. The Secretary may promulgate regulations regarding enrollment practices.

New Section 1876(f) provides that an enrolled Medicare beneficiary with a controversy regarding services or charges of $100 or more is entitled to a hearing before the Secretary and, if the amount is $1,000 or more, is entitled to have a judicial review of the Secretary's decision.

New Section 1876(g)(1) prohibits an HMO's premium rate, deductibles, coinsurance or copayments charged to enrolled Medicare beneficiaries from exceeding the actuarial value of the coinsurance and deductibles which would be applicable on the average to the HMO's enrolled Medicare beneficiaries if they were not enrolled.

New Section 1876(g)(2) provides that if the HMO provides services in addition to those covered by parts A and B, they must be at the option of the enrolled Medicare beneficiary or as approved by the Secretary, and the HMO must advise the enrolled beneficiary of the additional premium or charge for those additional services. The premium or the actuarial value of the deductible, coinsurance and copayment charged for the additional services may not exceed the "adjusted community rate" for those services.

New Section 1876(g)(3) defines the "adjusted community rate" for a service as, at the HMO's choice, either the rate of payment annually estimated by the Secretary that would apply in a HMO which uses the "community rating system" required by section 1302(8) of the Public Health Service Act, or the portion of the weighted aggregate premium attributable to that service, adjusted to reflect differences in utilization between enrolled Medicare beneficiaries and other HMO enrollees.

New Section 1876(g)(4) provides that if an enrolled Medicare beneficiary were also entitled to benefits under a worker's compensation law or an insurance policy, the HMO could charge under those other policies for services rendered.

New Section 1876(h) provides that no more than 75 percent of a participating HMO's total enrollment may be Medicare beneficiaries and Medicaid recipients. However, the Secretary of HHS can modify or waive this requirement as long as Medicare beneficiaries constitute no more than 50 percent of total enrollment.

New Section 1876(i)(1–2) authorizes the Secretary of HHS to enter into risk contracts with HMOs which choose to participate. The contract must provide that if the adjusted community rate for enrolled Medicare beneficiaries (reduced for the actuarial value of the coinsurance and deductibles) is less than the average of the per capita payments made to the HMO, the HMO must provide additional benefits which are, as determined by the Secretary of HHS at least equal in value to the difference between the adjusted community rate and the average per capita payment.

New Section 1876(i)(3) provides that the additional benefits would be (a) the reduction of the premium rate or other charges, or (b) the provision of additional health benefits, or both.

New Section 1876(i)(4) provides that each contract be for a term of at least one year and may be automatically renewable, except the Secretary may terminate the contract for specified reasons. The effective date of the contract shall be specified in the contract.

New Section 1876(i)(5) requires contracts with HMO's to provide that: (a) the Secretary or his designee could inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed and could audit or inspect any books and records of the HMO pertaining to the capacity of the organization to bear the risk of potential financial losses and pertaining to services performed or the determinations of amounts payable under the contract; (b) the HMO would have to provide written notice to its enrolled Medicare beneficiaries in advance of termination of the contract and alternatives for obtaining their Medicare benefits; and (c), other conditions determined by the Secretary to be necessary.

New Section 1876(i)(7) provides that if an HMO terminated a contract within the preceding five-year period, the Secretary could not agree to another contract except in special circumstances as determined by the Secretary.

New Section 1876(i)(8) provides that the Secretary of HHS may carry out this section without regard to other provisions of law regarding contracts which are inconsistent with this title.

New Section 1876(j) provides that if the Secretary determines that an HMO cannot bear the risk, or if an HMO so elects, the Secretary could enter into a contract with the HMO to reimburse the HMO on a reasonable cost basis. (This is the same option as in current law.) Provides certain requirements for reasonable cost contracts.

Section 203(b) and (c) amends section 1861(s)(2) and section 1861(aa)(3) to clarify that "medical and other health services" which an HMO must provide to an enrolled Medicare beneficiary may include the services of physician assistants and nurse practitioners.

Section 203(d) provides that the effective date be either (a) the first day of the thirteenth month after enactment, or (b) one month after the Secretary of HHS notifies the Committees on Ways and Means, Energy and Commerce, and Finance that the methodology to implement the new HMO payment system is developed as can be implemented, whichever is later. Provides that the new section not apply (1) to any Medicare beneficiary enrolled on the date a new risk contract is agreed to unless the beneficiary requests such application or the Secretary determines that administrative costs or burdens warrant such application and so informs each affected member; (2) for five years after the effective date, to an HMO which has a risk-based contract under current law or which, on the enactment date, is furnishing services according to an existing demonstration project which concludes before the effective date and before the HMO enters into an existing risk contract, unless the HMO requests earlier application; or (3) to an HMO which, on the enactment date, has an existing demonstration project which concludes after the effective date. Provides that an HMO with cost contract on the enactment date or a new cost contract after that date may not receive payment under new risk contract unless it enrolls two new Medicare enrollees for each nonrisk Medicare enrollee who converts. Provides the definition of certain terms.

Section 203(e) requires the Secretary to conduct a study of the additional benefits selected by HMOs with new risk contracts pursuant to new section 1876(i)(2) and report to the Congress within 24 months of the initial effective date of the findings and conclusions.

Section 203(f) requires the Secretary to conduct a study of the terminations by enrolled Medicare beneficiaries of their memberships in HMOs, emphasizing the quality and quantity of care provided in HMOs compared to that provided on a fee-for-service basis. Requires the Secretary to submit an interim report to Congress within 2 years and a final report within 5 years of the effective date. The study may be coordinated with that provided for under section 2178(d) of the Omnibus Budget Reconciliation Act of 1981.

SECTION 204. MEDICARE ENROLLMENT PROVISIONS FOR MERCHANT SEAMAN AND SPECIAL GENERAL ENROLLMENT PERIOD

Section 204(a) permits certain merchant seamen and other individuals to enroll in Parts A or B of the Medicare program, if such persons (at any time during a period beginning March 10, 1981 and ending October 1, 1981) were entitled to treatment and hospitalization under section 322(a) of the Public Health Service Act (as in effect on September 30, 1981) and were eligible to enroll in Medicare as of September 30, 1981. Such enrollment period would begin on the first day of the first month following enactment and end on December 31, 1982.

Section 204(b) provides that Medicare coverage for individuals who elect to enroll as provided for under subsection (a) would begin on the first day of the month following the month in which such individuals enroll or on October 1, 1981, if any individual files as requests such date and pays monthly premiums for the months so covered. Individuals who enrolled in Medicare before the enrollment period provided for under subsection (a) shall have coverage extended retroactively to October 1, 1981, if such individuals file a request for

retroactive extension before January 1, 1983 and pay monthly premiums for any months so covered.

Section 204(c) exempts individuals enrolling under subsection (a) from any increased monthly premium amounts that would result from delinquent enrollment (required by section 1839(d) of the Social Security Act). The exemption from the delinquent enrollment premium would not apply in the case of persons enrolled in Medicare before March 10, 1981 (unless such enrollment has terminated solely because of lost eligibility to be so enrolled) or unless such individuals apply for this exemption.

Section 204(d) directs the Secretary to disseminate information about the special benefits provided by this section to unions and other associations representing seamen, Medicare offices and other entities as soon as possible (but no later than 60 days) after enactment. The subsection also indicates the documentation appropriate for establishing eligibility to treatment and hospitalization under section 322(a) of the Public Health Service Act (as in effect before October 1, 1981).

Section 204(e) establishes a special general enrollment period for any person (who, as of the date of enactment of this section) is eligible to enroll in Part B for a period beginning on the first day of the first month beginning at least 20 days after the date of enactment and ending on December 31, 1982. Coverage for persons electing enrollment under this subsection shall begin on the first day of the month following the month in which the individual enrolls. Individuals enrolling under this subsection would be exempted from the increased monthly premium amounts that result from delinquent enrollment (required by section 1839(d) of the Social Security Act), except that the exemption would not apply to individuals previously enrolled in the Part B program (unless such previous enrollment was terminated solely because individuals lost eligibility to be so enrolled). The Secretary is also directed to disseminate information regarding the provisions of this subsection.

XI. Agency Views

No agency views were received.

XII. Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3 of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Social Security Act

TITLE V—MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

AUTHORIZATION OF APPROPRIATIONS

Sec. 501. (a) * * *

* * * * * * *

(b) For purposes of this title:

(1) The term "consolidated health programs" means the programs administered under the provisions of—

(A) this title (relating to maternal and child health and crippled children's services),

(B) section 1615(c) of this Act (relating to supplemental security income for disabled children),

(C) sections 316 (relating to lead-based paint poisoning prevention programs), 1101 (relating to genetic disease programs) and 1131 (relating to hemophilia treatment centers) of the Public Health Service Act, and

(D) title [IV] *VI* of the Health Services and Centers Amendments of 1978 (Public Law 95–626; relating to adolescent pregnancy grants),

as such provisions were in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act.

(2) The term "low income" means, with respect to an individual or family, such an individual or family with an income determined to be below the nonfarm income official poverty line defined by the Office of Management and Budget and revised annually in accordance with [section 624 of the Economic Opportunity Act of 1964] *section 673(2) of the Omnibus Budget Reconciliation Act of 1981.*

* * * * * * *

DESCRIPTION OF INTENDED EXPENDITURES AND STATEMENT OF ASSURANCES

SEC. 505. In order to be entitled to payments for allotments under section 502 for a fiscal year, a State must prepare and transmit to the Secretary—

(1) a report describing the intended use of payments the State is to receive under this title for the fiscal year, including (A) a description of those populations, areas, and localities in the State which the State has identified as needing maternal and child health services, (B) a statement of goals and objectives for meeting those needs, (C) information on the types of services to be provided and the categories or characteristics of individuals to be served, and (D) data the State intends to collect respecting activities conducted with such payments; and

(2) a statement of assurances that represents to the Secretary that—

(A) the State will provide a fair method (as determined by the State) for allocating funds allotted to the State under this title among such individuals, areas, and localities identified under paragraph (1)(A) as needing maternal and child health services, and the State will identify and apply guidelines for the appropriate frequency and content of, and appropriate referral and followup with respect to, health care assessments and services financially assisted by the State under this title and methods for assuring quality assessments and services;

(B) funds allotted to the State under this title will only be used, consistent with section 508, to carry out the purposes of

this title or to continue activities previously conducted under the consolidated health programs (described in section [502 (b)(1)] *501(b)(1)*;

(C) the State will use—

(i) a substantial proportion of the sums expended by the State for carrying out this title for the provision of health services to mothers and children, with special consideration given (where appropriate) to the continuation of the funding of special projects in the State previously funded under this title (as in effect before the date of the enactment of the Maternal and Child Health Services Block Grant Act), and

(ii) a reasonable proportion (based upon the State's previous use of funds under this title) of such sums to carry out the purposes described in paragraphs (1) through (3) of section 501(a);

(D) if [the State imposes any charges] *any charges are imposed* for the provision of health services assisted by the State under this title, such charges (i) will be pursuant to a public schedule of charges, (ii) will not be imposed with respect to services provided to low income mothers or children, and (iii) will be adjusted to reflect the income, resources, and family size of the individual provided the services; and

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TITLE XI—GENERAL PROVISIONS AND PROFESSIONAL STANDARDS REVIEW

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PART A—GENERAL PROVISIONS

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CIVIL MONETARY PENALTIES

SEC. 1128A. [(a) Any person (including an organization, agency, or other entity) that presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that the Secretary determines—

[(1) is for a medical or other item or service—

[(A) that the person knows or has reason to know was not provided as claimed, or

[(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), 1862(d), or 1866(b)(2), or

[(2) is submitted in violation of an agreement between the person and the United States or a State agency,]

(a) Any person (including an organization, agency, or other entity) that—

(1) presents or causes to be presented to an officer, employee, or agent of the United States, or of any department or agency thereof, or of any State agency (as defined in subsection (h)(1)), a claim (as defined in subsection (h)(2)) that the Secretary determines is for a medical or other item or service—

(A) that the person knows or has reason to know was not provided as claimed, or

(B) payment for which may not be made under the program under which such claim was made, pursuant to a determination by the Secretary under section 1128, 1160(b), or 1862(d), or pursuant to a determination by the Secretary under section 1866(b)(2) with respect to which the Secretary has initiated termination proceedings; or

(2) presents or causes to be presented to any person a request for payment which is in violation of the terms of (A) an assignment under section 1842(b)(3)(B)(ii), or (B) an agreement with a State agency not to charge a person wor an item or service in excess of the amount permitted to charged,

shall be subject, in addition to any other penalties that may be prescribed by law, to a civil money penalty of not more than $2,000 for each item or service. In addition, such a person shall be subject to an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the United States or a State agency because of such claim.

* * * * * * *

NONPROFIT HOSPITAL PHILANTHROPY

SEC. 1134. For purposes of determining, under titles XVIII and XIX of this Act, the reasonable costs of services provided by nonprofit hospitals, the following items shall not be deducted from the operating costs of such hospitals:

(1) A grant, gift, or endowment, or income therefrom, which is to or for such a hospital and which has not been designated by the donor for paying any specific operating costs.

(2) A grant or similar payment which is to such a hospital, which was made by a governmental entity, and which is not available under the terms of the grant or payment for use as operating funds.

(3) Those types of donor designated grants and gifts (including grants and similar payments which are made by a governmental entity), and income therefrom, which the Secretary determines, in the best interests of needed health care, should be encouraged.

(4) The proceeds from the [scale] *sale* or mortgage of any real estate or other capital asset of such a hospital, which real estate or asset the hospital acquired through gift or grant, if such proceeds are not available for use as operating funds under the terms of the gift or grant.

Paragraph (4) shall not apply to the recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets.

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TITLE XVI—GRANTS TO STATES FOR AID TO THE AGED, BLIND, OR DISABLED[, OR FOR SUCH AID FOR THE AGED]

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), [(B) with respect to expenses incurred for radiological or pathological services for which payment may be made under this part, furnished to an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1482(b)(3)(B)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, the amounts paid shall be equal to 100 percent of the reasonable charges for such services.] *(B) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services*, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to diagnostic tests performed in a laboratory for which payment is made under this part to the laboratory, the amounts paid shall be equal to 100 percent of the negotiated rate for such tests (as

determined pursuant to subsection (h) of this section), (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to expenses incurred for physicians' services (furnished by a physician who has an agreement in effect with the Secretary by which the physician agrees to accept an assignment, described in section 1842(b)(3)(B)(ii) with respect to payment for all physicians' services which are preadmission diagnostic services furnished by the physician to individuals enrolled under this part) which are preadmission diagnostic services for which payment may be made under this part and which are furnished (i) in the outpatient department of a hospital within seven days of such individual's admission to the same hospital as an inpatient or, to the extent practicable as determined by regulations prescribed by the Secretary, to another hospital, or (ii) to the extent practicable as determined by regulations prescribed by the Secretary, in a physician's office within seven days of such individual's admission to a hospital as an inpatient, the amounts paid shall be equal to the reasonable charges for such services, *and* (G) with respect to expenses incurred for services described in subsection (i)(3) under the conditions specified in such subsection, the amounts paid shall be the reasonable charge for such services, [and (H) with respect to items and services described in section 1861(s)(10), the amounts paid shall be 100 percent of the reasonable charges for such items and services,]

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $70; except that [(1 such total amount shall not include expenses incurred (A) for radiological or pathological services furnished to such individual as an inpatient of a hospital by a physician in the field of radiology or pathology who has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided for in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him to hospital inpatients enrolled under this part, or (B) for items and services described in section 1861(s)(10) *(1) such total amount shall not include expenses incurred for items and services described in section 1861(s)(10)*, (2) such deductible shall not apply with respect to home health services, and (3) such total amount shall not include expenses incurred for services the amount of payment for which is determined under subsection (a)(1)(G) or under subsection (i)(2) or (i)(4). The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for

such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined furnished such individual with respect to which a deduction is made under this sentence.

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USE OF CARRIERS FOR ADMINISTRATION OF BENEFITS

SEC. 1842. (a) * * *

* * * * * * *

(b)(1) Contracts with carriers under subsection (a) may be entered into without regard to section 3709 of the Revised Statutes or any other provision of law requiring competitive bidding.

(2) No such contract shall be entered into with any carrier unless the Secretary finds that such carrier will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as he finds pertinent.

(3) Each such contract shall provide that the carrier—

(A) will take such action as may be necessary to assure that, where payment under this part for a service is on a cost basis, the cost is reasonable cost (as determined under section 1861(v));

(B) will take such action as may be necessary to assure that, where payment under this part for a service is on a charge basis, such charge will be reasonable and not higher than the charge applicable, for a comparable service and under comparable circumstances, to the policyholders and subscribers of the carrier, and such payment will (except as otherwise provided in section 1870(f) be made—

(i) on the basis of an itemized bill; or

(ii) on the basis of an assignment under the terms of which (I) the reasonable charge is the full charge for the service (except in the case of physicians' services and ambulance service furnished as described in section 1862(a)(4), other than for purposes of section 1870(f)) and (II) the physician or other person furnishing such service agrees not to charge for such service if payment may not be made therefor by reason of the provisions of paragraph (1) of section 1862, and if the individual to whom such service was furnished was without fault in incurring the expenses of such service, and if the Secretary's determination that payment (pursuant to such assignment) was incorrect and was made subsequent to the third year following the year in which notice of such payment was sent to such individual; except that the Secretary may reduce such three-year period to not less than one year if he finds such reduction is consistent with the objectives of this title;

but (in the case of bills submitted, or requests for payment made, after March 1968) only if the bill is submitted, or a written request for payment is made in such other form as may be permitted under regulations, no later than the close of the calendar year following the year in which such service is furnished (deeming any service furnished in the last 3 months of any calendar year to have been furnished in the succeeding calendar year);

(C) will establish and maintain procedures pursuant to which an individual enrolled under this part will be granted an opportunity for a fair hearing by the carrier, in any case where the amount in controversy is $100 or more when requests for payment under this part with respect to services furnished him are denied or are not acted upon with reasonable promptness or when the amount of such payment is in controversy;

(D) will furnish to the Secretary such timely information and reports as he may find necessary in performing his functions under this part;

(E) will maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (D) and otherwise to carry out the purposes of this part; and

(F) will take such action as may be necessary to assure that where payment under this part for a service rendered is on a charge basis, such payment shall be determined on the basis of the charge that is determined in accordance with this section on the basis of customary and prevailing charge levels in effect at the time the service was rendered or, in the case of services rendered more than 12 months before the year (ending on June 30) in which the bill is submitted or request for payment is made, on the basis of such levels in effect for the 12-month period preceding such year;

and shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary or appropriate. In determining the reasonable charge for services for purposes of this paragraph, there shall be taken into consideration the customary charges for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services.

No charge may be determined to be reasonable in the case of bills submitted or requests for payment made under this part after December 31, 1970, if it exceeds the higher of (i) the prevailing charge recognized by the carrier and found acceptable by the Secretary for similar services in the same locality in administering this part on December 31, 1970, or (ii) the prevailing charge level that, on the basis of statistical data and methodology acceptable to the Secretary, would cover 75 percent of the customary charges made for similar services in the same locality during the last preceding calendar year elapsing prior to the start of the twelve-month period (beginning [July] *October* 1 of each year) in which the service is rendered. In the case of physician services the prevailing charge level determined for purposes of clause (ii) of the preceding sentence for any twelve-month period (beginning after June 30, 1973) specified in clause (ii) of such sentence may not exceed (in the aggregate) the level determined under such clause

for the fiscal year ending June 30, 1973, except to the extent that the Secretary finds, on the basis of appropriate economic index data, that such higher level is justified by economic changes. With respect to power-operated wheelchairs for which payment may be made in accordance with section 1861(s)(6), charges determined to be reasonable may not exceed the lowest charge at which power-operated wheelchairs are available in the locality. In the case of medical services, supplies, and equipment (including equipment servicing) that, in the judgment of the Secretary, do not generally vary significantly in quality from one supplier to another, the charges incurred after December 31, 1972, determined to be reasonable may not exceed the lowest charge levels at which such services, supplies, and equipment are widely and consistently available in a locality except to the extent and under the circumstances specified by the Secretary. The requirement in subparagraph (B) that a bill be submitted or request for payment be made by the close of the following calendar year shall not apply if (i) failure to submit the bill or request the payment by the close of such year is due to the error or misrepresentation of an officer, employee, fiscal intermediary, carrier, or agent of the Department of Health, Education, and Welfare performing functions under this title and acting within the scope of his or its authority, and (ii) the bill is submitted or the payment is requested promptly after such error or misrepresentation is eliminated or corrected. Notwithstanding the provisions of the third and fourth sentences preceding this sentence, the prevailing charge level in the case of a physician service in a particular locality determined pursuant to such third and fourth sentences for the twelve-month period beginning on [July] *October* 1 in any calendar year after 1974 shall, if lower than the prevailing charge level for the fiscal year ending June 30, 1975, in the case of a similar physician service in the same locality by reason of the application of economic index data, be raised to such prevailing charge level for the fiscal year ending June 30, 1975. The amount of any charges for outpatient services which shall be considered reasonable shall be subject to the limitations established by regulations issued by the Secretary pursuant to section 1861(v)(1)(K).

(4)(A) Subject to subparagraph (C), in determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services rendered during the 12-month period ending September 30, 1983, the Secretary shall not set any level higher than 104 percent of the level as was set for the 12-month period ending June 30, 1982.

(B) In determining the prevailing charge levels under the third and fourth sentences of paragraph (3) for physicians' services for periods beginning after September 30, 1983, subject to subparagraph (C), the Secretary shall treat the level as set under subparagraph (A) as having fully provided for economic changes which would have been taken into account but for the limitations contained in subparagraph (A).

(C) Subparagraph (A) shall not apply with respect to a 12-month period ending on September 30 with respect to a physician if the physician has in effect an agreement with the Secretary by which the physician agrees to accept an assignment (as provided in section 1842(b)(3)(B)(ii)) for all physicians' services furnished by him to individuals enrolled under this part during such period.

[(4)] (5) Each contract under this section shall be for a term of at least one year, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at anytime (after such reasonable notice and opportunity for hearing to the carrier involved as he may provide in regulations) if he finds that the carrier has failed substantially to carry out the contract or is carrying out the contract in a manner inconsistent with the efficient and effective administration of the insurance program established by this part.

[(5)] (6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that payment may be made (A) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (B) (where the service was provided in a hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or facility as described in clause (A) or (B) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment.

[(6)](7)(A) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), the carrier shall not provide (except on the basis described in subparagraph (C)) for payment for such services under this part—

"(i) unless—

"(I) the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought,

"(II) the services are of the same character as the services the physician furnishes to patients not entitled to benefits under this title, and

"(III) at least 25 percent of the hospital's patients (during a representative past period, as determined by the Secretary) who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) paid all or a substantial part of charges (other than nominal charges) imposed for such services; and

"(ii) to the extent that the amount of the payment exceeds the reasonable charge for the services (with the customary charge determined consistent with subparagraph (B)).

"(B) The customary charge for such services in a hospital shall be determined in accordance with regulations issued by the Secretary and taking into account the following factors:

"(i) In the case of a physician who has a substantial practice outside the teaching setting, the carrier shall take into account the amounts the physician charges for similar services in the physician's outside practice.

"(ii) In the case of a physician who does not have a practice described in clause (i), if the hospital, its physicians, or other appropriate billing entity has established one or more schedules of charges which are collected for medical and surgical services, the carrier shall base payment under this title on the greater of—

"(I) the charges (other than nominal charges) which are most frequently collected in full or substantial part with respect to patients who were not entitled to benefits under this title and who were furnished services described in subclauses (I) and (II) of subparagraph (A)(i), or

"(II) the mean of the charges (other than nominal charges) which were collected in full or substantial part with respect to such patients.

"(C) In the case of physicians' services furnished to a patient in a hospital with a teaching program approved as specified in section 1861(b)(6) but which does not meet the conditions described in section 1861(b)(7), if the conditions described in subclauses (I) and (II) of subparagraph (A)(i) are met and if the physician elects payment to be determined under this subparagraph, the carrier shall provide for payment for such services under this part on the basis of regulations of the Secretary governing reimbursement for the services of hospital-based physicians (and not on any other basis).

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Part C—Miscellaneous Provisions

definitions of services, institutions, etc.

Sec. 1861. For purposes of this title—

Spell of Illness

(a) * * *

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Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) physicians' services;

(2) (A) services and supplies (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) furnished as an incident to a physician's professional service, of kinds which are commonly furnished in physicians' offices and are commonly either rendered without charge or included in the physicians' bills;

(B) hospital services (including drugs and biologicals which cannot, as determined in accordance with regulations, be self-administered) incident to physicians' services rendered to outpatients;

(C) diagnostic services which are—

(i) furnished to an individual as an outpatient by a hospital or by others under arrangements with them made by a hospital, and

(ii) ordinarily furnished by such hospital (or by others under such arrangements) to its outpatients for the purpose of diagnostic study;

(D) outpatient physical therapy services;

(E) rural health clinic services;

(F) home dialysis supplies and equipment, self-care home dialysis support services, and institutional dialysis services and supplies; [and]

(G) antigens (subject to quantity limitations prescribed in regulations by the Secretary) prepared by a physician, as defined in section 1861(r)(1), for a particular patient, including antigens so prepared which are forwarded to another qualified person (including a rural health clinic) for administration to such patient, from time to time, by or under the supervision of another such physician; *and*

(H) services furnished pursuant to a contract under section 1876 to a member of a health maintenance organization by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service to such a member as would otherwise be covered under this part if furnished by a physician or as an incident to a physician's service;

* * * * * * *

Rural Health Clinic Services

(aa)(1) The term "rural health clinic services" means—

(A) physicians' services and such services and supplies as are covered under section 1861(s)(2)(A) if furnished as an incident to a physician's professional service and items and services described in section 1861(s)(10),

(B) such services furnished by a physician assistant or by a nurse practitioner and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

(C) in the case of a rural health clinic located in an area in which there exists a shortage of home health agencies, part-time or intermittent nursing care and related medical supplies (other than drugs and biologicals) furnished by a registered professional nurse or licensed practical nurse to a homebound individual under a written plan of treatment (i) established and periodically reviewed by a physician described in paragraph (2)(B), or (ii) established by a nurse practitioner or physician assistant and periodically reviewed and approved by a physician described in paragraph (2)(B),

when furnished to an individual as an outpatient of a rural health clinic.

(2) The term "rural health clinic" means a facility which—

(A) is primarily engaged in furnishing to outpatients services described in subparagraphs (A) and (B) of paragraph (1);

(B) in the case of a facility which is not a physician-directed clinic, has an arrangement (consistent with the provisions of State and local law relative to the practice, performance, and delivery of health services) with one or more physicians (as defined in subsection (r)(1)) under which provision is made for the periodic review by such physicians of covered services furnished by physician assistants and nurse practitioners, the supervision and guidance by such physicians of physician assistants and nurse practitioners, the preparation by such physicians of such medical orders for care and treatment of clinic patients as may be necessary, and the availability of such physicians for such referral of and consultation for patients as is necessary and for advice and assistance in the management of medical emergencies; and, in the case of a physician-directed clinic, has one or more of its staff physicians perform the activities accomplished through such an arrangement;

(C) maintains clinical records on all patients;

(D) has arrangements with one or more hospitals, having agreements in effect under section 1866, for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic;

(E) has written policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more physician assistants or nurse practitioners, to govern those services described in paragraph (1) which it furnishes;

(F) has a physician, physician assistant, or nurse practitioner responsible for the execution of policies described in subparagraph (E) and relating to the provision of the clinic's services;

(G) directly provides routine diagnostic services, including clinical laboratory services, as prescribed in regulations by the Secretary, and has prompt access to additional diagnostic services from facilities meeting requirements under this title;

(H) in compliance with State and Federal law, has available for administering to patients of the clinic at least such drugs and biologicals as are determined by the Secretary to be necessary for

the treatment of emergency cases (as defined in regulations) and has appropriate procedures or arrangements for storing, administering, and dispensing any drugs and biologicals;

(I) has appropriate procedures for review of utilization of clinic services to the extent that the Secretary determines to be necessary and feasible; and

(J) meets such other requirements as the Secretary may find necessary in the interest of the health and safety of the individuals who are furnished services by the clinic.

For the purposes of this title, such term includes only a facility which (i) is located in an area that is not an urbanized area (as defined by the Bureau of the Census) and that is designated by the Secretary either (I) as an area with a shortage of personal health services under section 1302(7) of the Public Health Service Act or (II) as a health manpower shortage area described in section 332(a)(1)(A) of that Act because of its shortage of primary medical care manpower, (ii) has filed an agreement with the Secretary by which it agrees not to charge any individual or other person for items or services for which such individual is entitled to have payment made under this title, except for the amount of any deductible or coinsurance amount imposed with respect to such items or services (not in excess of the amount customarily charged for such items and services by such clinic), pursuant to subsections (a) and (b) of section 1833, (iii) employs a physician assistant or nurse practitioner, and (iv) is not a rehabilitation agency or a facility which is primarily for the care and treatment of mental diseases. A facility that is in operation and qualifies as a rural health clinic under this title or title XIX and that subsequently fails to satisfy the requirement of clause (i) shall be considered, for purposes of this title and title XIX, as still satisfying the requirement of such clause.

* * * * * * *

Physician Assistant and Nurse Practitioner

[(3)] (*dd*) The term "physician assistant" and the term "nurse practitioner" mean[, for the purposes of paragraphs (1) and (2),] a physician assistant or nurse practitioner who performs such services as such individual is legally authorized to perform (in the State in which the individual performs such services) in accordance with State law (or the State regulatory mechanism provided by State law), and who meets such training, education, and experience requirements (or any combination thereof) as the Secretary may prescribe in regulations.

* * * * * * *

[PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

[SEC. 1876. (a)(1) In lieu of amounts which would otherwise be payable pursuant to sections 1814(b) and 1833(a), the Secretary is authorized to determine, by actuarial methods, as provided in this section, but only with respect to a health maintenance organization with which he has entered into a contract under subsection (i), a per capita rate of payment—

[(A) for services provided under parts A and B for individuals enrolled with such organization pursuant to subsection (e) who are entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B, and

[(B) for services provided under part B for individuals enrolled with such organization pursuant to subsection (e) who are not entitled to benefits under part A but who are enrolled for benefits under part B.

[(2) An interim per capita rate of payment for each health maintenance organization shall be determined annually by the Secretary on the basis of each organization's annual operating budget and enrollment forecast which shall be submitted (in such form and in such detail as the Secretary may prescribe) at least 90 days before the beginning of each contract year. Each interim rate shall be equal to the estimated per capita cost (based upon types and components of expenses otherwise reimbursable under this title) of providing services defined in paragraph (3)(A)(iii). In the event that the data requested to be furnished by a health maintenance organization are not furnished timely, such reduction in interim payments may be made by the Secretary as is appropriate, until such time as a reasonable estimate of per capital costs can be made. Each month, the Secretary shall pay each such organization its interim per capita rate, in advance, for each individual enrolled with it pursuant to subsection (e). Each such organization shall submit interim estimated cost reports and enrollment data on a quarterly basis in such form and manner satisfactory to the Secretary, and the Secretry shall adjust each interim per capita rate to the extent necessary to maintain interim payments at the level of current costs. Interim payments made under this paragraph shall be subject to retroactive adjustment at the end of each contract year as provided in paragraph (3).

[(3)(A) With respect to any health maintenance organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A), payments made to such organization shall be subject to the following adjustments at the end of each contract year:

[(i) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing services described in paragraph (1) is less than the adjusted average per capita incurred cost (as defined herein) of providing such services, the resulting difference (hereinafter referred to as "savings") shall be apportioned following the close of a contract year for such year between such organization and the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (hereinafter collectively referred to as the "Medicare Trust Funds") as follows:

[(I) savings up to 20 percent of the adjusted average per capita cost shall be apportioned equally between such organization and the Medicare Trust Funds;

[(II) savings in excess of 20 percent of the adjusted average per capita cost shall be apportioned entirely to such Trust Funds;

[(ii) if the Secretary determines that the per capita incurred cost of any such organization in any contract year for providing

services described in paragraph (1) is greater than the adjusted average per capita incurred cost of providing such services, the resuling difference (hereinafter referred to as "losses"), shall be absorbed by such organization, and shall be carried forward and offset from savings realized in later years;

[(iii) determination of any amounts payable at the close of the contract year to such organization or to the Trust Funds shall be made as follows:

[(I) within 90 days after close of a contract year, interim determination of the amount of estimated savings and apportionment thereof shall be made, actuarially, on the basis of interim reports of costs incurred by an organization, and adjusted average per capita costs incurred (as defined herein), and other evidence acceptable to the Secretary and one-half of any amounts deemed payable to such organization or the Trust Funds shall be paid by such organization or the Secretary as appropriate;

[(II) final settlement and payment by the Secretary or organization, as appropriate, of any additional amounts due on basis of such final settlement will be made where adequate data for actuarial computation are available, in timely fashion following submission by such organization of reports specified in subparagraph (C) of this paragraph; and

[(III) where such final settlement is reached more than 90 days following submission of reports specified in subparagraph (C) of this paragraph, any amount payable by the Secretary or organization shall be increased by an interest amount, accruing from the 91st day following submission of such report, equal to the average rate of interest payable on Federal obligations if issued on such 91st day for purchase by the Trust Funds.

[(iv) The term "adjusted average per capita cost" means the average per capita amount that the Secretary determines (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in the geographic area served by a health maintenance organization or in a similar area, with appropriate adjustment to assure actuarial equivalence, including adjustments relating to age distribution, sex, race, institutional status, disability status, and any other relevant factors) would be payable in any contract year for services covered under this title and types of expenses otherwise reimbursable under this title (including administrative costs incurred by organizations described in sections 1816 and 1842) if such services were to be furnished by other than such health maintenance organization.

[(B) With respect to any health maintenance organization which has entered into a reasonable cost reimbursement contract with the Secretary pursuant to subsection (i)(2)(B), payments made to such organization shall be subject to suitable retroactive corrective adjustments at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding therefrom any part of incurred cost found to be unnecessary in the

efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in paragraph (1).

[(C) Any contract with a health maintenance organization under this title shall provide that the Secretary shall require, at such time following the expiration of each accounting period of a health maintenance organization (and in such form and in such detail) as he may prescribe:

[(i) that such health maintenance organization report to him in an independently certified financial statement its per capita incurred cost based on the types and components of expenses otherwise reimbursable under this title for providing services described in paragraph (1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

[(ii) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

[(iii) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v) of the Social Security Act; and

[(iv) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

[(4) The payments to health maintenance organizations under this subparagraph with respect to individuals described in subsection (a)(1)(A) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of such payment to such an organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

[(A) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(1), and

[(B) the product of (i) the number of covered enrollees of such organization for such month (as described in paragraph (1)) who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for such month as determined under section 1839(c)(4).

[The remainder of such payment shall be paid by the former trust fund. For limitation on Federal participation for capital expenditures which are out of conformity with a comprehensive plan of a State or areawide planning agency, see section 1122.

[(b)(1) The term "health maintenance organization" means a legal entity which provides health services on a prepayment basis to individuals enrolled with such organizations and which—

[(A) provides to its enrollees who are insured for benefits under parts A and B of this title or for benefits under part B alone, through institutions, entities, and persons meeting the applicable requirements of section 1861, all of the services and benefits covered under such parts (to the extent applicable under subparagraph (A) or (B) of subsection (a)(1)) which are available to individuals residing in the geographic area served by the organization:

[(B) provides such services in the manner prescribed by section 1301(b) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term "basic health services" and reference thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be required to fix the basic health services payment under a community rating system;

[(iii) the additional nominal payments authorized by section 1301(b)(1)(D) of such Act shall not exceed the limits applicable under subsection (g) of this section; and

[(iv) payment for basic health services provided by the organization to its enrollees under this section or for services such enrollees receive other than through the organization shall be made as provided for by this title;

[(C) is organized and operated in the manner prescribed by section 1301(c) of the Public Health Service Act, except that solely for the purposes of this section—

[(i) the term 'basic health services' and references thereto shall be deemed to refer to the services and benefits included under parts A and B of this title;

[(ii) the organization shall not be reimbursed for the cost of reinsurance except as permitted by subsection (i) of this section; and

[(iii) the organization shall have an open enrollment period as provided for in subsection (k) of this section.

[(2)(A) The duties and functions of the Secretary, insofar as they involve making determinations as to whether an organization is a 'health maintenance organization' within the meaning of paragraph (1), shall be administered through the Assistant Secretary for Health and in the Office of the Assistant Secretary for Health, and the administration of such duties and functions shall be integrated with the administration of section 1312 (a) and (b) of the Public Health Service Act.

[(B) Except as provided in subparagraph (A), the Secretary shall administer the provisions of this section through the Administrator of the Health Care Financing Administration.

[(c) The benefits provided under this section to enrollees of an organization which has entered into a risk sharing contract with the Secretary pursuant to subsection (i)(2)(A) shall consist of—

[(1) in the case of an individual who is entitled to hospital insurance benefits under part A and enrolled for medical insurance benefits under part B—

[(A) entitlement to have payment made on his behalf for all services described in section 1812 and section 1832 which are furnished to him by the health maintenance organization with which he is enrolled pursuant to subsection (e) of this section; and

[(B) entitlement to have payment made by such health maintenance organization to him or on his behalf for (i) such emergency services (as defined in regulations), (ii) such urgently needed services (as defined in regulations) furnished to him during a period of temporary absence (as defined in regulations) from the geographic area served by the health maintenance organization with which he is enrolled, and (iii) such other services as may be determined, in accordance with subsection (f), to be services which the individual was entitled to have furnished by the health maintenance organization, as may be furnished to him by a physician, supplier, or provider of services, other than the health maintenance organization with which he is enrolled; and

[(2) in the case of an individual who is not entitled to hospital insurance benefits under part A but who is enrolled for medical insurance benefits under part B, entitlement to have payment made for services described in paragraph (1), but only to the extent that such services are also described in section 1832.

[(d) Subject to the provisions of subsection (e), every individual described in subsection (c) shall be eligible to enroll with any health maintenance organization (as defined in subsection (b)) which serves the geographic area in which such individual resides.

[(e) An individual may enroll with a health maintenance organization under this section, and may terminate such enrollment, as may be prescribed by regulations.

[(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive without additional cost to him any health services to which he believes he is entitled shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b) and in any such hearing the Secretary shall make such health maintenance organization a party thereto. If the amount in controversy is $1,000 or more, such individual or health maintenance organization shall be entitled to judicial review of the Secretary's final decision after such hearing as is provided in section 205(g).

[(g)(1) If the health maintenance organization provides its enrollees under this section only the services described in subsection (c), its premium rate or other charges for such enrollees shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B, if they were not enrolled under this section.

[(2) If the health maintenance organization provides to its enrollees under this section services in addition to those described in subsection (c), election of coverage for such additional services shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. The portion of its premium rate or other charges applicable to the services described in subsection (c) shall not exceed the actuarial value of the deductible and coinsurance which would otherwise be applicable to such enrollees under part A and part B if they were not enrolled under this section.

[(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have an enrolled membership at least half of which consists of individuals who have not attained age 65.

[(2) The Secretary may waive the requirement imposed in paragraph (1) for a period of not more than three years from the date a health maintenance organization first enters into an agreement with the Secretary pursuant to subsection (i), but only for so long as such organization demonstrates to the satisfaction of the Secretary by the submission of its plan for each year that it is making continuous efforts and progress toward compliance with the provisions of paragraph (1) within such three-year period.

[(i)(1) Subject to the limitations contained in subparagraphs (A) and (B) of paragraph (2), the Secretary is authorized to enter into a contract with any health maintenance organization which undertakes to provide, on an interim per capita prepayment basis, the services described in section 1832 (and section 1812, in the case of individuals who are entitled to hospital insurance benefits under part A) to individuals enrolled with such organization pursuant to subsection (e).

[(2)(A) If the health maintenance organization (i) has a current enrollment of not less than 25,000 members on a prepaid capitation basis and has been the primary source of health care of at least 8,000 persons in each of the two years immediately preceding the contract year, or (ii) serves a nonurban geographic area, has a current enrollment of not less than 5,000 members on a prepaid capitation basis and has been the primary source of health care for at least 1,500 persons in each of the three years immediately preceding the contract year, the Secretary may enter into a risk sharing contract with such organization pursuant to which any savings, as determined pursuant to subsection (a)(3)(A), are shared between such organization and the Medicare Trust Funds in the manner prescribed in such subsection. For purposes of this subparagraph, a health maintenance organization shall be considered to serve a nonurban geographic area if it is located in a nonmetropolitan county (that is, a county with fewer than 50,000 inhabitants), or if it has at least one such county in its normal service area, or if it is located outside of a metropolitan area and its facilities are within reasonable travel distance (as defined by the Secretary) of fewer than 50,000 individuals. No health maintenance organization which has entered into a risk-sharing contract with the Secretary under this subparagraph and has voluntarily terminated such contract may again enter into such a contract.

[(B) If the health maintenance organization does not meet the requirements of subparagraph (A), or if the Secretary is not satisfied that the health maintenance organization has the capacity to bear the risk of potential losses as determined under clause (ii) of subsection (a)(3)(A), or if the health maintenance organization meeting the requirements of subparagraph (A) so elects, or if an organization does not fully meet the requirements of section 1876(b) but has demonstrated to the satisfaction of the Secretary that it is making reasonable efforts to meet, and is developing the capability to fully meet, such requirements, and that it fully meets such basic requirements as the Secretary shall prescribe in regulations, the Secretary may, if he is otherwise satisfied that the health maintenance organization or other organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in subsection (a)(3)(B).

[(3) Such contract may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities for the reasonable cost (as determined under section 1861(v) of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payments which would otherwise be made to such organization. If a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

[(4) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (A) has failed substantially to carry out the contract, (B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (C) no longer substantially meets the applicable conditions of subsection (b).

[(5) The effective date of any contract executed pursuant to this subsection shall be specified in such contract pursuant to the regulations.

[(6) Each contract under this section—

[(A) shall provide that the Secretary, or any person or organization designated by him—

[(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under such contract; and

[(ii) shall have the right to audit and inspect any books and records of such health maintenance organization which pertain to services performed and determinations of amounts payable under such contract;

[(B) shall provide that no reinsurance costs (other than costs with respect to out-of-area services and, in the case of an organization which has entered into a risk-sharing contract with the Secretary pursuant to paragraph (2)(A), the cost of providing any member with basic health services the aggregate value of which exceeds $5,000 in any year), including any underwriting of risk relating to costs in excess of adjusted average per capita cost, as defined in clause (iii) of subsection (a)(3)(A), shall be allowed for purposes of determining payments authorized under this section; and

[(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

[(j) The function vested in the Secretary by subsection (i) may be performed without regard to such provisions of law or of other regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

[(k) Each health maintenance organization with which the Secretary enters into a contract under this section shall have an open enrollment period at least every year under which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (d) in the order in which they apply for enrollment (unless to do so would result in failure to meet the requirements of subsection (h)) or would result in enrollment of enrollees susbtantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by such health maintenance organization.]

PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS

SEC. 1876. (a)(1) The Secretary shall annually determine—

(A) a per capita rate of payment for each class of individuals who are enrolled (in accordance with this section) with a health maintenance organization which has entered into a contract under this section (other than under subsection (j)) and who are entitled to benefits under part A and enrolled under part B, and

(B) a per capita rate of payment for each class of individuals who are so enrolled with such an organization and who are enrolled under part B only.

Such rate for each class shall be equal to 95 percent of the adjusted average per capita cost for that class.

(2) For purposes of this section, the term "adjusted average per capita cost" means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by a health maintenance organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B, or part B only, and types of expenses otherwise reimbursable under parts A and B,

or part B only (including administrative costs incurred by organizations described in sections 1816 and 1842), if the services were to be furnished by other than a health maintenance organization or, in the case of services covered only under section 1861(s)(2)(H), if the services were to be furnished by a physician or as an incident to a physician's service.

(3) In establishing classes of individuals for purposes of this subsection, the Secretary shall take into consideration such factors as age, institutional status, disability status, and place of residence, and such other factors as the Secretary determines to be appropriate.

(4) After determining under paragraph (1) the rate of payment to be utilized with respect to a health maintenance organization, the Secretary shall make monthly payments, in advance and in accordance with such rate, except as provided in subsections (i)(2) and (j), to such organization for each individual enrolled in accordance with this section with the organization. Such payments (and payments made under subsection (j)) shall be in lieu of payments which (in the absence of the contract entered into under this section) would be payable otherwise pursuant to sections 1814(b) and 1833(a) for services furnished by or through the organization to individuals enrolled with the organization and entitled to benefits under part A and enrolled under part B or enrolled under part B only.

(5) The payment to a health maintenance organization under this section for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled under part B shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund. The portion of that payment to the organization for a month to be paid by the latter trust fund shall be equal to 200 percent of the sum of—

(A) the product of (i) the number of such individuals for the month who have attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(1), and

(B) the product of (i) the number of such individuals for the month who have not attained age 65, and (ii) the monthly actuarial rate for supplementary medical insurance for the month as determined under section 1839(c)(4).

The remainder of that payment shall be paid by the former trust fund.

(b)(1) For purposes of this section, the term "health maintenance organization" means a public or private organization, organized under the laws of any State, which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act) or which—

(A) provides to enrolled members at least the following health care services: physicians' services performed by physicians (as defined in section 1861(r)(1)), in patient hospital services, laboratory, X-ray, emergency, and preventive services, and out-of-area coverage;

(B) is compensated (except for deductibles, coinsurance, and copayments) for the provision of health care services to enrolled members by a payment which is paid on a periodic basis without

regard to the date the health care services are provided and which is fixed without regard to the frequency, extent, or kind of health care service actually provided;

(C) provides physicians' services primarily (i) directly through physicians who are either employees or partners of such organization, or (ii) through contracts with individual physicians or one or more groups of physicians (organized on a group practice or individual practice basis);

(D) assumes full financial risk on a prospective basis for the provision of the health care services listed in subparagraph (A), except that such organization may—

(i) obtain insurance or make other arrangements for the cost of providing to any enrolled member health care services listed in subparagraph (A) the aggregate value of which exceeds $5,000 in any year,

(ii) obtain insurance or make other arrangements for the cost of health care service listed in subparagraph (A) provided to its enrolled members other than through the organization because medical necessity required their provision before they could be secured through the organization,

(iii) obtain insurance or make other arrangements for not more than 90 percent of the amount by which its costs for any of its fiscal years exceed 115 percent of its income for such fiscal year, and

(iv) make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions; and

(E) has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary.

(2) The Secretary may not enter into a contract with a health maintenance organization under this section, unless, with respect to individuals enrolled with the organization under this section, the following requirements are met:

(A) BENEFIT PACKAGE.—The organization must provide to such individuals who are—

(i) entitled to benefits under part A and enrolled under part B, only those services covered under parts A and B of this title, or

(ii) only enrolled under part B, only those services covered under such part,

except that, in addition, the organization (other than an organization with a contract under subsection (j)) may provide such individuals with such additional health care services either as the Secretary may approve or as such individuals may elect, at their option, to have covered. The Secretary shall approve any such additional health care services which the organization proposes to offer to such individuals, unless the Secretary determines that including such additional services will substantially discourage enrollment by covered individuals with the organization.

(B) Limits on deductibles, coinsurance, and copayments.—The amount of any deductibles, coinsurance, and copayments required of such individuals will not exceed the limits applicable under subsection (g) of this section.

(C) Providers.—The organization must provide the services described in subparagraph (A) to such individuals through institutions, entities, and persons meeting the applicable requirements of the title and of part A of title XI.

(D) Open enrollment.—The organization must have an open enrollment period, for the enrollment of individuals under this section, of reasonable duration at least every year during which it accepts up to the limits of its capacity and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (a) in the order in which they apply for enrollment, unless to do so would result in failure to meet the requirements of subsection (h) or would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

(E) Expulsion of members.—The organization must (i) provide assurances to the Secretary that it will not expel or refuse to re-enroll any such individual because of the individual's health status or requirements for health care services, and (ii) notify each such individual of such fact at the time of the individual's enrollment.

(F) Availability of services.—The organization must—

(i) make the services described in subparagraph (A) (and such other health care services as such individuals have contracted for) (I) available and accessible to each such individual, within the area served by the organization, promptly as appropriate and in a manner which assures continuity, and (II) when medically necessary, available and accessible twenty-four hours a day and seven days a week, and

(ii) provide for reimbursement with respect to services which are described in clause (i) and which are provided to such an individual other than through the organization, if the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition.

(G) Grievance procedures.—The organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and such individuals.

(H) Quality assurance.—The organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (i) stresses health outcomes and (ii) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

(c) If an individual is enrolled in accordance with this section with a health maintenance organization (other than an organization with

a contract under subsection (i)), only the health maintenance organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

(d) Subject to the provisions of subsection (e), every individual entitled to benefits under part A and enrolled under part B or enrolled under part B only (other than an individual medically determined to have end-stage renal disease) shall be eligible to enroll under this section with any health maintenance organization with which the Secretary has entered into a contract under this section and which serves the geopraphic area in which the individual resides.

(e) (1) An individual may enroll under this section with a health maintenance organization in such manner as may be prescribed in regulations and may terminate his enrollment with the health maintenance organization as of the beginning of the first calendar month following a full calendar month after the request is made for such termination or, in the case of such an organization with a contract under subsection (j), as may be prescribed by regulations.

(2) The Secretary may prescribe the procedures and conditions under which a health maintenance organization that has entered into a contract with the Secretary under this subsection may inform individuals eligible to enroll under this section with the organization about the organization, or may enroll such individuals with the organization.

(f) Any individual enrolled with a health maintenance organization under this section who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay shall, if the amount in controversy is $100 or more, be entitled to a hearing before the Secretary to the same extent as is provided in section 205(b), and in such hearing the Secretary shall make the health maintenance organization a party. If the amount in controversy is $1,000 or more, the individual or health maintenance organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the health maintenance organization shall be entitled to be parties to that judicial review.

(g) (1) In no case may—

(A) the portion of a health maintenance organization's premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under parts A and B) to individuals who are enrolled in accordance with this section with the organization and who are entitled to benefits under part A and enrolled under part B, or

(B) the portion of its premium rate and the actuarial value of its deductibles, coinsurance, and copayments charged (with respect to services covered under part B) to individuals who are enrolled in accordance with this section with the organization and enrolled under part B only

exceed the actuarial value of the coinsurance and deductibles that would be applicable on the average to individuals enrolled in accordance with this section with the organization (or, if the Secretary finds that adequate data are not available to determine that actuarial value,

other appropriate data) and entitled to benefits under part A and enrolled under part B, or enrolled under part B only, respectively, if they were not members of a health maintenance organization.

(2) If the health maintenance organization provides to its enrollees under this section services in addition to services covered under part A and B of this title, election of coverage for such additional services (unless such services have been approved by the Secretary under subsection (b)(2)(A)) shall be optional for such enrollees and such organization shall furnish such enrollees with information on the portion of its premium rate or other charges applicable to such additional services. Except for an organization with a contract under subsection (j), in no case may the sum of—

(A) the portion of such organization's premium rate charged, with respect to such additional services, to individuals enrolled in accordance with this section, and

(B) the actuarial value of its deductibles, coinsurance, and copayments charged, with respect to such services to such individuals exceed the adjusted community rate for such services.

(3) For purposes of this section, the term "adjusted community rate" for a service means, at the election of a health maintenance organization, either—

(A) the rate of payment for that service which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with a health maintenance organization if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to an individual enrolled in accordance with this section with the health maintenance organization, as the Secretary annually estimates is attributable to that service,

but adjusted for differences between the utilization characteristics of the individuals enrolled with the health maintenance organization under this section and the utilization characteristics of the other members of the organization (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals in other health maintenance organizations, or individuals in the area, in the State, or in the United States, eligible to enroll under this section with a health maintenance organization and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

(4) Notwithstanding any other provision of law, the health maintenance organization may (in the case of the provision of services to an individual enrolled in accordance with this section for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

(A) the insurance carrier, employer, or other entity which under such law or policy is to pay for the provision of such services, or

(2) such member to the extent that such member has been paid under such law or policy for such services.

(h)(1) Except as provided in paragraph (2), each health maintenance organization with which the Secretary enters into a contract under this section shall have, for the duration of such contract, an enrolled membership at least one-quarter of which consists of individuals who are not entitled to benefits under part A or enrolled under part B or entitled to benefits under a State plan approved under title XIX.

(2) The Secretary may modify or waive the requirement imposed by paragraph (1) only (A) if the Secretary determines that (i) special circumstances warrant such modification or waiver, and (ii) the health maintenance organization has taken and is making reasonable efforts to enroll individuals who are not entitled to benefits under this title or under a State plan approved under title XIX, and (B) on the condition that the organization will not have, for the duration of such contract, an enrolled membership of which one-half or more are individuals entitled to benefits under part A or enrolled under part B.

(i)(1) The Secretary may enter a contract with any health maintenance organization, as defined in subsection (b)(1), for the purpose of carrying out this section.

(2) Each contract (other than a contract described in subsection (j)) shall provide that—

(A) if the adjusted community rate, as defined in subsection (g)(3), for services under parts A and B (as reduced for the actuarial value of the coinsurance and deductibles under those parts) for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or

(B) if the adjusted community rate for services under part B (as reduced for the actuarial value of the coinsurance and deductibles under that part) for individuals enrolled in accordance with this section with the organization and entitled to benefits under part B only

is less than the average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of an annual contract period for individuals enrolled in accordance with this section with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the health maintenance organization shall provide to individuals enrolled in accordance with this section (other than under a contract under subsection (j)) with the organization and entitled to benefits under part A and enrolled in part B, or enrolled in part B only, respectively, the additional benefits which are selected by the health maintenance organization and which the Secretary finds are at least equal in value to the difference between the average per capita payment and the adjusted community rate (as so reduced); except that this paragraph shall not apply with respect to any organization which elects to receive a lesser payment to the extent that there is no longer a difference between the average per capita

payment and adjusted community rate (as so reduced). If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (a)(1) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

(3) Such additional benefits shall be (A) the reduction of the premium rate or other charges made with respect to services furnished by the organization to individuals enrolled under this section, or (B) the provision of additional health benefits, or both.

(4)(A) Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the health maintenance organization involved as he may provide in regulations), if he finds that the organization (i) has failed substantially to carry out the contract, (ii) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this section, or (iii) no longer substantially meets the applicable conditions of subsection (b).

(B) The effective date of any contract executed pursuant to this section shall be specified in the contract.

(5) Each contract under this section—

(A) shall provide that the Secretary, or any person or organization designated by him—

(i) shall have the right to inspect or otherwise evaluate the quality, appropriateness, and timeliness of services performed under the contract, and

(ii) shall have the right to audit and inspect any books and records of the health maintenance organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

(B) shall require the organization (other than an organization with a contract under subsection (j)) to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this section with the organization; and

(C) shall contain such other terms and conditions not inconsistent with this section as the Secretary may find necessary.

(7) The Secretary may not enter into a contract with a health maintenance organization under this section (other than under subsection (j)) if a former contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

(8) The authority vested in the Secretary by this subsection may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of

contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

(j) (1) If—

(A) the Secretary is not satisfied that a health maintenance organization has the capacity to bear the risk of potential losses under a risk-sharing contract under this section, or

(B) the health maintenance organization so elects, the Secretary may, if he is otherwise satisfied that the health maintenance organization is able to perform its contractual obligations effectively and efficiently, enter into a contract with such organization pursuant to which such organization is reimbursed on the basis of its reasonable cost (as defined in section 1861(v)) in the manner prescribed in paragraph (3), rather than on the basis described in subsection (a) (4).

(2) Such contract under this subsection may, at the option of such organization, provide that the Secretary (A) will reimburse hospitals and skilled nursing facilities either for the reasonable cost (as determined under section 1861(v)) or in accordance with section 1886, as applicable, of services furnished to individuals enrolled with such organization pursuant to subsection (e), and (B) will deduct the amount of such reimbursement from payment which would otherwise be made to such organization. If such a health maintenance organization pays a hospital or skilled nursing facility directly, the amount paid shall not exceed the reasonable cost of the services (as determined under section 1861(v)) or the applicable amount established under section 1886 unless such organization demonstrates to the satisfaction of the Secretary that such excess payments are justified on the basis of advantages gained by the organization.

(3) Payments made to an organization with a contract under this subsection shall be subject to appropriate retroactive corrective adjustment at the end of each contract year so as to assure that such organization is paid for the reasonable cost actually incurred (excluding any part of incurred cost found to be unnecessary in the efficient delivery of health services) for the types of expenses otherwise reimbursable under this title for providing services covered under this title to individuals described in subsection (a) (1).

(4) Any contract with a health maintenance organization under this subsection shall provide that the Secretary shall require, at such time following the expiration of each accounting period of the health maintenance organization (and in such form and in such detail) as he may prescribe—

(A) that the organization report to him in an independently certified financial statement its per capita incurred cost based on the types of components of expenses otherwise reimbursable under this title for providing services described in subsection (a) (1), including therein, in accordance with accounting procedures prescribed by the Secretary, its methods of allocating costs between individuals enrolled under this section and other individuals enrolled with such organization;

(B) that failure to report such information as may be required may be deemed to constitute evidence of likely overpayment on the basis of which appropriate collection action may be taken;

(C) that in any case in which a health maintenance organization is related to another organization by common ownership or control, a consolidated financial statement shall be filed and that the allowable costs for such organization may not include costs for the types of expense otherwise reimbursable under this title, in excess of those which would be determined to be reasonable in accordance with regulations (providing for limiting reimbursement to costs rather than charges to the health maintenance organization by related organizations and owners) issued by the Secretary in accordance with section 1861(v); and

(D) that in any case in which compensation is paid by a health maintenance organization substantially in excess of what is normally paid for similar services by similar practitioners (regardless of method of compensation), such compensation may as appropriate be considered to constitute a distribution of profits.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

[(A) for making medical assistance available, including at least care and services listed in paragraphs (1) through (5) and (17) of section 1905(a), to all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A or part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplemental security income benefits are being paid under title XVI;]

(A) for making medical assistance available, including at least the care and services listing in paragraphs (1) through (5) and (17) of section 1905(a), to—

(i) all individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, XVI, or part A or part E of title IV (including pregnant women deemed by the State to be receiving such aid as authorized in section 406(g) and individuals considered by the State to be receiving such aid as authorized under section 414(g)), or with respect to whom supplementary security income benefits are being paid under title XVI; and

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the

case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) who meet the income and resources requirements of the appropriate State plan described in clause (i) (or would meet those requirements if child care costs were paid from earnings or if coverage under the appropriate State plan were as broad as allowed under Federal law), or the supplemental security income program (as the case may be), or

(II) with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, aid or assistance under the appropriate State plan, supplemental security income benefits under title XVI, or a State supplementary payment;

(B) that the medical assistance made available to any individual described in subparagraph (A)—

(i) shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual, and

(ii) shall not be less in amount, duration, or scope than the medical assistance made available to individuals not described in subparagraph (A);

(C) that if medical assistance is included for any group of individuals described in section 1905(a) who are not described in subparagraph (A), then—

(i) the plan must include a description of (I) the criteria for determining eligibility of individuals in the group for such medical assistance [and (II)], *(II)* the amount, duration, and scope of medical assistance made available to individuals in the group, *and (III) the single standard to be employed in determining income and resource eligibility for all such groups, and the methodology to be employed in determining such eligibility, which shall be the same methodology which would be employed under the supplemental security income program in the case of groups consisting of aged, blind, or disabled individuals in a State in which such program is in effect, and which shall be the same methodology which would be employed under the appropriate State plan (described in subparagraph (A)(i)) to which such group is most closely categorically related in the case of other groups*;

(ii) the plan must make available medical assistance—

(I) to individuals [described in section 1905(a)(i)] *under the age of 18 who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A)(i),* **and**

(II) to pregnant women, during the course of their pregnancy, who (but for income and resources) would be eligible for medical assistance as an individual described in subparagraph (A);

(iii) such medical assistance must include (I) with respect to children under 18 and individuals entitled to institutional services, ambulatory services, and (II) with respect to pregnant women, prenatal care and delivery services; and

(iv) if such medical assistance includes services in institutions for mental diseases or intermediate care facility services for the mentally retarded (or both) for any such group, it also must include for all groups covered at least the care and services listed in paragraphs (1) through (5) and (17) of section 1905(a) or the care and services listed in any 7 of the paragraphs numbered (1) through (17) of such section; and

(D) for the inclusion of home health services for any individual who, under the State plan, is entitled to skilled nursing facility services;

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals) or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of this title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, [and] (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary, with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A) *and (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under paragraph (14)(A)(ii) or (14)(B)(ii) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or*

service furnished to an individual who is eligible for such exemption;

(14) [effective January 1, 1973,] provide that—

(A) in case of individuals receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, or with respect to whom supplemental security income benefits are being paid under title XVI, or whom meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be, and individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)—

[(i) no enrollment fee, premium, or similar charge, and no deduction, cost sharing, or similar charge with respect to the care and services listed in paragraphs (1) through (5), (7), and (17) of section 1905(a), will be imposed under the plan, and

[(ii) any deduction, cost sharing, or similar charge imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), and]

(i) no enrollment fee, premium, or similar charge will be imposed under the plan;

(ii) no deduction, cost sharing, or similar charge will be imposed with respect to care and services—

(I) furnished to an individual who is an inpatient in a skilled nursing or intermediate care facility,

(II) which are furnished to a pregnant woman or are care and services related to pregnancy (including post-partum services),

(III) furnished to an individual under 21 years of age or to an individual who is enrolled as a member of a health maintenance organization (as defined in section 1903(m)), or

(IV) which are emergency services (as defined by the Secretary) or which are services described in section 1905(a)(4)(C); and

(iii) any deduction, cost sharing, or similar charge otherwise imposed under the plan with respect to—

(I) services listed in section 1905(a)(1) may not exceed 1$ per day,

(II) services listed in paragraphs (2), (5), and (9) of section 1905(a) may not exceed $1 per visit, and

(III) other care and services will be nominal in amount (as determined in accordance with stand-

ards approved by the Secretary and included in the plan),

except that a charge of up to $4 per visit may be imposed for the services received at an emergency room of a hospital if the services are not emergency services (referred to in clause (ii)(III) and the State has established to the satisfaction of the Secretary that individuals eligible for services under the plan have actually available and accessible to them alternative sources of nonemergency, outpatient services,

(B) with respect to individuals (other than individuals with respect to whom there is being paid, or who are eligible or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in paragraph (10)(A)) who are not receiving aid or assistance under any such State plan and with respect to whom supplemental security income benefits are not being paid under title XVI and who do not meet the income and resources requirements of the appropriate State plan, or the supplemental security income program under title XVI, as the case may be,

(i) there may be imposed an enrollment fee, premium, or similar charge which (as determined in accordance with standards prescribed by the Secretary) is related to the individual's income, [and]

[(ii) any deductible, cost-sharing, or similar charge imposed under the plan will be nominal;]

(ii) no deduction, cost sharing, or similar charge will be imposed with respect to care and services—

(I) which are furnished to a pregnant woman or are care and services related to pregnancy (including post-partum services),

(II) furnished to an individual under 21 years of age, or

(III) which are emergency services (as defined by the Secretary) or which are services described in section 1905(a)(4)(C), and

(iii) any deduction, cost sharing, or similar charge otherwise imposed under the plan with respect to other care and services will be nominal in amount (as determined in accordance with standards approved by the Secretary and included in the plan), except that a charge of up to $4 per a visit may be imposed for the services received at an emergency room of a hospital if the services are not emergency services (referred to in subparagraph (A)(ii)(III)) and the State has established to the satisfaction of the Secretary that individuals eligible for services the under plan have actually available and accessible to them alternative sources of nonemergency, outpatient services, and

(C) no provider participating under the State plan may deny care or services to an individual eligible for such care or services under the plan on account of such individual's inability to pay a deduction, cost sharing, or similar charge;

[(18) provide that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan (except pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual), and that there shall be no adjustment or recovery (except, in the case of an individual who was 65 years of age or older when he received such assistance, from his estate, and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under age 21 or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or is blind or disabled as defined in section 1614 (with respect to States which are not eligible to participate in such program) of any medical assistance correctly paid on behalf of such individual under the plan;]

(18) provide—

(A) that no lien may be imposed against the property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the plan except—

(i) pursuant to the judgment of a court on account of benefits incorrectly paid on behalf of such individual, or

(ii) in the case of the real property of an individual who is an inpatient in a skilled nursing or intermediate care facility who the State establishes, after notice and opportunity for a hearing (in accordance with procedures established by the State), is reasonably likely to remain in the facility as an inpatient for the remainder of his life;

(B) that a lien imposed pursuant to subparagraph (A)(ii) shall dissolve upon the individual's discharge from the facility and return home; and

(C) that there shall be no adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the plan, except—

(i) in the case of an individual who was 65 years of age or older when he received such assistance or with respect to property subject to a lien imposed pursuant to subparagraph (A)(ii) or a trust established under clause (ii) relating to such a lien, from the individual's estate or such trust upon the individual's death, or

(ii) in the case of property which is subject to a lien imposed pursuant to subparagraph (A)(ii) and which has been sold, the proceeds of the sale pertaining to the lien shall be put into a trust (meeting such terms as the Secretary shall provide, including permitting the income to be used for the reasonable care are maintenance of a spouse and children under 21 years of age or without age limit if under a disability) and, if the lien (with respect

to which the trust was established) would otherwise have been dissolved pursuant to subparagraph (B), the trust shall be terminated and the corpus of the trust shall revert to the individual,

and then only after the death of his surviving spouse, if any, and only at a time when he has no surviving child who is under 21 years of age or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614, or, in the case of a lien on the individual's home. only at a time when no sibling, son, or daughter of the individual (who was residing in the individual's home for a period of at least one year immediately before date of the individual's admission to the facility) is lawfully residing in the home;

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes as a condition for eligibility for medical assistance under the plan—

(1) an age requirement of more than 65 years; or

[(2) any age requirement which excludes any individual who has not attained the age of 19 and is a dependent child under part A of title IV;]

[(3)] *(2)* any residence requirement which excludes any individual who resides in the State; or

[(4)] *(3)* any citizenship requirement which excludes any citizen of the United States.

(e)(1) Notwithstanding any other provision of this title, effective January 1, 1974, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family became ineligible for such aid because of increased hours of, or increased income from, employment, shall, while a member of such family is employed, remain eligible for assistance under the plan approved under this title (as though the family was receiving aid under the plan approved under part A of title IV) for 4 calendar months beginning with the month in which such family became ineligible for aid under the plan approved under part A of title IV because of income and resources or hours of work limitations contained in such plan.

(2)(A) In the case of an individual who is enrolled with a qualified health maintenance organization (as defined in title XIII of the Public Health Service Act) under a contract described in section 1903(m)(2)(A) and who would (but for this paragraph) lose eligibility for benefits under this title before the end of the minimum enrollment period (defined in subparagraph (B)), the State plan may provide, notwithstanding any other provision of this title, that the individual shall be deemed to continue to be eligible for such benefits until the end of such minimum period, but only with respect to such benefits provided to the individual as an enrollee of such organization.

(B) For purposes of subparagraph (A), the term "minimum enroll-

ment period" means, with respect to an individual's enrollment with a health maintenance organization under a State plan, a period, established by the State, of not more than six months beginning on the date the individual's enrollment with the organization becomes effective.

(3) Any individual who—

(A) is 18 years of age or younger and qualifies as a disabled individual under section 1614(a);

(B) with respect to whom there has been a determination by the State that—

(i) the individual requires a level of care provided in a hospital, skilled nursing facility, or intermediate care facility,

(ii) it is appropriate to provide such care for the individual outside such an institution, and

(iii) the estimated amount which would be expended for medical assistance for the individual for such care outside an institution is not greater than the estimated amount which would otherwise be expended for medical assistance for the individual within an appropriate institution; and

(C) if the individual were in a medical institution, would be eligible to have a supplemental security income (or State supplemental) payment made with respect to him under title XVI,

shall be deemed, for purposes of this title only, to be an individual with respect to whom a supplemental security income payment, or State supplemental payment, respectively, is being paid under title XVI.

(4)(A) A State may treat, for purposes of the State's plan approved under this title, as an individual receiving aid or assistance under the plan of the State approved under part A of title IV, an individual who would be eligible for such aid or assistance under such plan but for any or all of the limitations or requirements described in subparagraph (B), if the individual meets such alternative requirements as the State may provide for under subparagraph (C).

(B) The limitations and requirements referred to in subparagraph (A) are as follows:

(i) The limitation to $75 in any month in section 402(a)(8)(A)(ii) on the total amount of the disregard from earned income for work expenses.

(ii) The limitation to $160 in any month in section 402(a)(8)(A)(iii) on the total amount of the disregard from earned income for certain child care (and other care) expenses.

(iii) The fact that the earned income disregard contained in section 402(a)(8)(A)(iv) is only computed after the disregards described in clauses (ii) and (iii) of section 402(a)(8)(A) are taken.

(iv) The limitation in section 402(a)(8)(B)(ii) to 4 months on the period for which the disregard described in section 402(a)(8)(A)(iv) can be taken and to 12 consecutive months on the length of the additional minimum period which must expire before such disregard can be taken again.

(v) The provisions of sections 402(d)(1) and 402(a)(17) as they require an earned income advance amount (under section

3507(a) of the Internal Revenue Code of 1954) or a refund of Federal income tax by reason of the earned income tax credit (under section 43 of the Internal Revenue Code of 1954) to be considered as income for any month other than the month in which the amount or refund is actually received.

(vi) The limitation to 150 percent of the State's need standard under section 402(a)(18) on the total income that families may have and still be eligible for aid under part A of title IV.

(C) With respect to the alternative requirements referred to in subparagraph (A), in lieu of the limitation or requirement referred to in—

(i) clause (i) of subparagraph (B), the State may provide for a dollar limitation on the disregard in section 402(a)(8)(A)(ii) equal to an amount greater than $75;

(ii) clause (ii) of subparagraph (B), the State may provide for a dollar limitation on the disregard in section 402(a)(8)(A)(iii) equal to an amount greater than $160;

(iii) clause (iv) of subparagraph (B), the State may provide that the disregard described in section 402(a)(8)(A)(iv) shall not apply after a period (specified by the State) of longer than the 4 months described in section 402(a)(8)(B)(ii) or may again apply after the expiration of an additional period (specified by the State) of less than the 12 consecutive months described in section 402(a)(8)(B)(ii)(II);

(iv) clause (v) of subparagraph (B), the State may provide that receipt of a refund of Federal income tax by reason of the earned income tax credit may result in ineligibility for a period (specified by the State) of less than that provided under section 402(a)(17); and

(v) clause (vi) of subparagraph (B), the State may substitute a percentage (greater than 150 percent) for the percent specified in section 402(a)(18).

Nothing in this paragraph shall be construed as requiring a State to provide for any alternative requirement described in this subparagraph.

* * * * * * *

(j)(1) Notwithstanding any other provision of this title, an individual who would otherwise be eligible for medical assistance under the State plan approved under this title may be denied such assistance if such individual would not be eligible for such medical assistance but for the fact that he disposed of resources for less than fair market value. If the State plan provides for the denial of such assistance by reason of such disposal of resources, the State plan shall specify a procedure for implementing such denial which, except as provided in paragraph (2), is not more restrictive than the procedure specified in section 1613(c) of this Act.

(2)(A) In any case where the uncompensated value of disposed of resources exceeds $12,000, the State plan may provide for a period of ineligibility which exceeds 24 months. If a State plan provides for a period of ineligibility exceeding 24 months, such plan shall provide for the period of ineligibility to bear a reasonable relationship to such uncompensated value.

(B)(i) Except as provided in clause (ii), in the case of an individual who is an inpatient in a skilled nursing or intermediate care facility who the State establishes, after notice and opportunity for a hearing (in accordance with procedures established by the State)—

(I) is reasonably likely to remain in the facility as an inpatient for the remainder of his life, and

(II) at any time during or after the twenty-fourth month prior to the month in which the individual applied for assistance under the plan, disposed of a home for less than its fair market value, the State plan may provide that the individual is ineligible for medical assistance with respect to any items and services furnished while an inpatient in such a facility for the period determined in accordance with clause (iii) beginning with the month in which the home was disposed of.

(ii) An individual shall not be ineligible for assistance under clause (i) if—

(I) title to the home was transferred to the individual's spouse or child who is under 21 years of age or (with respect to States eligible to participate in the State program established under title XVI), is blind or permanently and totally disabled, or (with respect to States which are not eligible to participate in such program) is blind or disabled as defined in section 1614,

(II) the individual demonstrates to the satisfaction of the State (in accordance with regulations promulgated by the Secretary) that the individual intended to dispose of the home either at fair market value or for other valuable consideration, or

(III) the State determines that denial of eligibility would work an undue hardship.

(iii) The period of ineligibility referred to in clause (i), imposed with respect to services furnished to an individual as an inpatient of a facility and because of the transfer of a home for less than fair market value, must be computed in a manner such that the cost of such services that would otherwise be made available to the individual during the period bears a reasonable relationship (in accordance with regulations promulgated by the Secretary) to the amount of the uncompensated value of the home.

PAYMENT TO STATES

SEC. 1903. (a) * * *

* * * * * * *

(g)(1) Subject to paragraph (3), with respect to amounts paid for the following services furnished under the State plan after June 30, 1973 (other than services furnished pursuant to a contract with a health maintenance organization as defined in section 1876 *or which is a qualified health maintenance organization (as defined in section 1310(d) of the Public Health Service Act)*, the Federal medical assistance percentage shall be decreased as follows: After an individual has received care as an inpatient in a hospital (including an institution for tuberculosis), skilled nursing facility or intermediate care facility on 60 days, or in a hospital for mental diseases on 90 days (whether or not such days are consecutive), during any fiscal year,

which for purposes of this section means the four calendar quarters ending with June 30, the Federal medical assistance percentage with respect to amounts paid for any such care furnished thereafter to such individual in the same fiscal year shall be decreased by a per centum thereof unless the State agency responsible for the administration of the plan makes a showing satisfactory to the Secretary that, with respect to each calendar quarter for which the State submits a request for payment at the full Federal medical assistance percentage for amounts paid for inpatient hospital services (including tuberculosis hospitals), skilled nursing facility services, or intermediate care facility services furnished beyond 60 days (or inpatient mental hospital services furnished beyond 90 days), there is in operation in the State an effective program of control over utilization of such services; such a showing must include evidence that—

(A) in each case for which payment is made under the State plan, a physician certifies at the time of admission, or, if later, the time the individual applies for medical assistance under the State plan (and the physician, or a physician assistant or nurse practitioner under the supervision of a physician, recertifies, where such services are furnished over a period of time, in such cases, at least every 60 days (or, in the case of services that are [intermediate care facility services described in section 1905(d)] *intermediate care facility services provided in an institution for the mentally retarded*, every year) and accompanied by such supporting material, appropriate to the case involved, as may be provided in regulations of the Secretary), that such services are or were required to be given on an inpatient basis because the individual needs or needed such services; and

* * * * * * *

(k) The Secretary is authorized to provide at the request of any State (and without cost to such State) such technical and actuarial assistance as may be necessary to assist such State to contract with any health maintenance organization which meets the requirements of [section 1876] *subsection (m) of this section* for the purpose of providing medical care and services to individuals who are entitled to medical assistance under this title.

(m)(1) * * *

(2)(A) Except as provided in subparagraphs (B) and (C), no payment shall be made under this title to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity which is responsible for the provision of inpatient hospital services and any other service described in paragraphs (2), (3), (4), (5), or (7) of section 1905(a) or for the provision of any three or more of the services described in such paragraphs unless—

(i) the Secretary (or the State as authorized by paragraph (3)) has determined that the entity is a health maintenance organization as defined in paragraph (1);

* * * * * * *

(iv) such contract provides that the Secretary and the State (or any person or organization designated by either) shall have the right to audit and inspect any books and records of the entity

(and of any subcontractor) that pertain (I) to the ability of the entity to bear the risk of potential financial losses, [and] *or* (II) to services performed or determinations of amounts payable under the contract;

* * * * * * *

(vii) such contract provides that, in the case of medically necessary services which were provided (I) to an individual enrolled with the entity under the contract and entitled to benefits with respect to such services under the State's plan and (II) other than through the organization because the services were immediately required due to an [unforseen] *unforeseen* illness, injury, or condition, either the entity or the State provides for reimbursement with respect to those services.

* * * * * * *

(s)(1)(A) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State is otherwise entitled to receive under this title for any quarter in—

(i) fiscal year 1982, shall be reduced by 3 percent,

(ii) fiscal year 1983, shall be reduced by 4 percent, and

(iii) fiscal year 1984, shall be reduced by 4.5 percent,

of the amount to which the State is otherwise entitled ([without regard to payments under subsection (t) and] *without regard to payments under subsections (a)(6) and (t), without regard to payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service, and* without regard to payments for claims relating to expenditures [made before fiscal year 1981] *made before fiscal year 1982*).

(B) No reduction may be made under subparagraph (A) for a quarter unless, as of the first day of the quarter, the Secretary has promulgated and has in effect final regulations (on an interim or other basis) implementing paragraphs (10)(C) and (13)(A) of section 1902(a) (as amended by the Medicare and Medicaid Amendments of 1981).

(C) For purposes of this paragraph, the term "State" only includes the fifty States and the District of Columbia and does not include any State which did not have *a program in operation under* a plan approved under this title as of July 1, 1981.

* * * * * * *

(3) For purposes of paragraph (2)(A), a State has a qualified hospital cost review program for a calendar quarter if such program meets the following requirements:

(A) The program must have been established by statute and in effect [on July 1, 1981, and] at the beginning of the quarter.

* * * * * * *

(D) The Secretary [determines that] *must determine that* the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the State during the [most recent calendar year] *year (which shall consist of a 12-month period determined by the Secretary for this purpose)* ending at least nine months before such quarter (or, at the State's option, during the [2 or 3 calendar-year period] *2- or 3-*

year period ending with that calendar year) is at least two percentage points less than the annual rate of increase during that [calendar] year (or that period, as the case may be) in such costs per capita or per admission for hospitals located in the United States (excluding from such computation, with respect to any [calendar] year in any period, any State which had in existence a qualified hospital cost review program (or, in the case of periods before January 1, 1982, had a hospital cost review program which the Secretary determines met for such periods the provisions of subparagraphs (A), (B), and (C) of this paragraph) during that entire [calendar] year).

(4) (A) For purposes of paragraph (2) (B), a State has a high unemployment rate with respect to a quarter if the average of the monthly unemployment rates (as determined by the Bureau of Labor Statistics) for the State for the three months immediately before such quarter is equal to or greater than 150 percent of the average of such rates for the United States for such months.

(B) For purposes of subparagraph (A), *and paragraph (3) (D)*, the term "United States" only includes the fifty States and the District of Columbia.

(5) (A) For purposes of paragraph (2) (C), the term "third party and fraud and abuse recoveries" means, for a State for a previous quarter—

(i) the total amount that State demonstrates to the Secretary that it has recovered or diverted (*including amounts saved, to the extent such amounts can be documented to the satisfaction of the Secretary, by reason of the suspension or termination of a provider or other person for fraud or abuse, but only during the period of such suspension or termination or, if shorter, the 1-year period beginning on the date of such termination or suspension*) in the quarter on the basis of (I) third-party payments (described in section 1902(a) (25)), (II) the operation of its State medicaid fraud control unit (defined in subsection (q)), and (III) other fraud or abuse control activities, plus

(ii) any amount carried forward from the previous quarter under subparagraph (B).

Subclause (I) of clause (i) shall only apply to quarters during fiscal year 1982.

(B) If the total amount of the State's third party and fraud and abuse recoveries (defined in subparagraph (A)) for a quarter (beginning on or after October 1, 1981) exceeds one percent of the amount of Federal payments that the Secretary estimates are due the State under this title for that quarter (without regard to subsection (t)), the amount of such excess shall be carried forward to the following quarter *or quarters* for purposes of clause (ii) of subparagraph (A).

(t) (1) The Secretary shall determine for each State (as defined in subsection (s) (1) (C)) for each of fiscal years 1982, 1983, and 1984, a target amount of Federal medicaid expenditures. Such target amount for a State for fiscal year—

(A) 1982, is equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretary before April 1, 1981) of the Federal share of expenditures under this title ([other than interest paid under subsection (d) (5)]

other than payments under subsection (a)(6), interest paid under subsection (a)(5), and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service, without taking into account reductions in payment under subsection (s) or additional payments under this subsection, and without regard to payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State;

(B) 1983, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the [consumer price index for all urban consumers (published by the Bureau of Labor Statistics)] *Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics* [between September 1982 and September 1983] *for the 12-month period ending September 1983;* and

(C) 1984, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the [consumer price index for all urban consumers (published by the Bureau of Labor Statistics)] *Consumer Price Index for all urban consumers (U.S. city average) published by the Bureau of Labor Statistics* [between September 1982 and September 1984. *for the 24-month period ending September 1984.*

(2) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State (with a State plan approved under this title) is otherwise entitled to receive for the first quarter of any fiscal year (beginning with fiscal year 1983 and ending with fiscal year 1985) shall be supplemented by an amount equal to the lesser of—

(A) the amount by which the Secretary determines or estimates (subject to appropriate subsequent adjustments) the Federal share of expenditures under this title ([other than interest paid under subsection (d)(5)] *other than payments under subsection (a)(6), interest paid under subsection (d)(5), and payments for claims relating to expenditures made for medical assistance for services received through a facility of the Indian Health Service*, without taking into account reductions in payment under subsection (s) or payments under this subsection, without regard to payments for claims relating to expenditures made prior to October 1, 1980, and subject to paragraph (3) of this subsection) under the State's plan for the previous fiscal year was less than the target amount of Federal medicaid expenditures for that State for that fiscal year determined under paragraph (1), or

(B) the amount of the reductions imposed with respect to the State under subsection (s) for the quarters in the previous fiscal year.

[(3) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal year 1984 (in the case of the payment which may be made for the first quarter of fiscal year 1985), the Federal medical assistance percentage for fiscal year

1984 shall be the Federal medical assistance percentage for States in effect for fiscal year 1983, disregarding any change in such percentage between fiscal year 1983 and fiscal year 1984.]

(3) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal years 1982, 1983, and 1984 (in the case of the payment which may be made for the first quarter of fiscal years 1983, 1984, and 1985, respectively), the Federal medical assistance percentage for fiscal years 1982, 1983, and 1984 shall be the Federal medical assistance percentage for States in effect for fiscal year 1981, disregarding any change in such percentage after fiscal year 1981.

Definitions

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose, [or any reasonable category of such individuals,]

* * * * * * *

(vi) persons essential (as described in the second sentence of this subsection) to individuals receiving aid or assistance under State plans approved under title I, X, XIV, or XVI, [or]

(vii) blind or disabled as defined in section 1614, with respect to States not eligible to participate in the State plan program established under title XVI, *or*

(*viii*) *pregnant women*,

but whose income and resources are insufficient to meet all of such cost—

(1) inpatient hospital services (other than services in an institution for tuberculosis or mental diseases);

* * * * * * *

PROVISIONS RESPECTING INAPPLICABILITY AND WAIVER OF CERTAIN REQUIREMENTS OF THIS TITLE

SEC. 1915. (a) * * *

(b) The Secretary, to the extent he finds it to be cost-effective and efficient and not inconsistent with the purposes of this title, may waive such requirements of section 1902 [and section 1903(m)] as may be necessary for a State—

(1) to implement a *primary care* case-management system or a specialty physician services arrangement which restricts the provider from (or through) whom an individual (eligible for medical assistance under this title) can obtain [primary] *medical* care services (other than in emergency circumstances), if such restriction does not substantially impair access to such services of adequate quality where medically necessary,

* * * * * * *

(c) (1) The Secretary may by waiver provide that a State plan approved under this part may include as "medical assistance" under such plan *payment for part or all of the cost of* home or community-based services (other than room and board) approved by the Secretary which are provided pursuant to a written plan of care to individuals with respect to whom there has been a determination that but for the provision of such services the individuals would require the level of care provided in a skilled nursing facility or intermediate care facility the cost of which could be reimbursed under the State plan.

(2) A waiver shall not be granted under this subsection unless the State provides assurances satisfactory to the Secretary that—

(A) necessary safeguards (including adequate standards for provider participation) have been taken to protect the health and welfare of individuals provided services under the waiver and to assure financial accountability for funds expended with respect to such services;

[(B) the State will provide, with respect to individuals who are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan and who may require such services, for an evaluation of the need for such services:]

(B) the State will provide, with respect to individuals who—

(i) are entitled to medical assistance for skilled nursing facility or intermediate care facility services under the State plan,

(ii) may require such services, and

(iii) may be eligible for such home or community-based care under such waiver,

for an evaluation of the need for such services;

* * * * * * *

(3) A waiver granted under this subsection may include a waiver of the requirements of [subsection (a) (1)] *section 1902(a)(1)* (relating to statewideness) and subsection (a) (10) [of section 1902]. A waiver under this subsection shall be for an initial term of three years and, upon the request of a State, shall be extended for additional three-year periods unless the Secretary determines that for the previous three-year period the assurances provided under paragraph (2) have not been met.

(4) A waiver granted under this [section] *subsection* may, consistent with paragraph (2)—

(A) limit the individuals provided benefits under such waiver to individuals with respect to whom the State has determined that there is a reasonable expectation that the amount of medical assistance provided with respect to the individual under such

waiver will not exceed the amount of such medical assistance provided for such individual if the waiver did not apply, and

(B) provide medical assistance to individuals (to the extent consistent with written plans of care, which are subject to the approval of the State) for case management services, homemaker/home health aide services and personal care services, adult day health services, habilitation services, respite care, and such other services requested by the State as the Secretary may approve.

* * * * * * *

(f) A request to the Secretary from a State for *approval of* a proposed State plan or plan amendment or a waiver of a requirement of this title submitted by the State pursuant to a provision of this title shall be deemed granted unless the Secretary, within 90 days after the date of its submission to the Secretary, either denies such request in writing or informs the State agency in writing with respect to any additional information which is needed in order to make a final determination with respect to the request. After the date the Secretary receives such additional information, the request shall be deemed granted unless the Secretary, within 90 days of such date, denies such request.

DELAYED OFFSET PAYMENTS TO CERTAIN STATES

Sec. 1916. (a) A State may elect to have this section apply in lieu of any offset in the percentage reduction under section 1903(s)(2)(A) (relating to States with qualified hospital cost review programs) for all quarters occurring in fiscal year 1983 and for all quarters occurring in fiscal year 1984.

(b) If the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) for calendar year 1983 or calendar year 1984 in a State with an election in effect under subsection (a) for the fiscal year ending in that calendar year is less than the State target rate of increase (as defined in subsection (c)(1)) for that calendar year, the Secretary shall provide for an adjustment in the amount of payment made to the State under this title so that the State will receive an additional amount equivalent to the additional amount it would have been paid under this title if the State had a qualified hospital cost review program (described in section 1903(s)(2)(3)) for each of the quarters of the fiscal year involved.

(c) As used in this section:

(1) In the case of a State for calendar year 1983 or calendar year 1984—

(A) if the State base rate (as defined in paragraph (2)) is less than the United States base rate (as defined in paragraph (3)), the "State target rate of increase" for that State for that year is a rate of increase determined under the formula: R x (N–2), where "R" is the ratio of the State base rate to the United States base rate for that year and "N" is the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the United States for the year involved; or

(B) if the State base rate (as defined in paragraph (2)) is equal to or greater than the United States base rate (as defined in paraggraph (3)), the "State target rate of increase" for that State for that year is a rate of increase equal to 2 percentage points less than the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the United States for the year involved.

(2) The term "State base rate" means, for a State for calendar year 1983 or calendar year 1984, the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the State in the 3-calendar-year period preceding such year.

(3) The term "United States base rate" means, for calendar year 1983 or calendar year 1984, the annual rate of increase in aggregate hospital inpatient costs per capita or per admission (as defined by the Secretary) in the United States in the 3-calendar-year period preceding such year.

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OMNIBUS BUDGET RECONCILIATION ACT OF 1981

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TITLE XXI—MEDICARE, MEDICAID, AND MATERNAL AND CHILD HEALTH

* * * * * * *

Subtitle C—Provisions Relating to Medicaid

CHAPTER 1—CHANGES IN PAYMENTS TO STATES

REDUCTION IN MEDICAID PAYMENTS TO STATES AND OFFSET FOR MEETING FEDERAL MEDICAID EXPENDITURE TARGETS

SEC. 2161. (a) * * *

(b) Section [1902] *1903* of such Act is further amended by adding after subsection (s) (added by subsection (a) of this section) the following new subsection:

"(t)(1) The Secretary shall determine for each State (as defined in subsection (s)(1)(C)) for each for fiscal years 1982, 1983, and 1984, a target amount of Federal medicaid expenditures. Such target amount for a State for fiscal year—

"(A) 1982, is equal to 109 percent of the estimate (based upon the last such estimate for such State received by the Secretary before April 1, 1981) of the Federal share of expenditures under this title (other than interest paid under subsection (d)(5), without taking into account reductions in payment under subsection (s) or additional payments under this subsection, and without

regard to payments for claims relating to expenditures made prior to October 1, 1980) in fiscal year 1981 for such State;

"(B) 1983, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the consumer price index for all urban consumers (published by the Bureau of Labor Statistics) between September 1982 and September 1983; and

"(C) 1984, is equal to the target amount determined under subparagraph (A) for the State increased or decreased by a percentage equal to the percentage increase or decrease (as the case may be) in the index of the medical care expenditure category of the consumer price index for all urban consumers (published by the Bureau of Labor Statistics) between September 1982 and September 1984.

(2) Notwithstanding any other provision of this section (except as otherwise provided in this subsection), the amount of payments which a State (with a State plan approved under this title) is otherwise entitled to receive for the first quarter of any fiscal year (beginning with fiscal year 1983 and ending with fiscal year 1985) shall be supplemented by an amount equal to the lesser of—

(A) the amount by which the Secretary determines or estimates (subject to appropriate subsequent adjustments) the Federal share of expenditures under this title (other than interest paid under subsection (d)(5), without taking into account reductions in payment under subsection (s) or payments under this subsection, without regard to payments for claims relating to expenditures made prior to October 1, 1980, and subject to paragraph (3) of this subsection) under the State's plan for the previous fiscal year was less than the target amount of Federal medicaid expenditures for that State for that fiscal year determined under paragraph (1), or

(B) the amount of the reductions imposed with respect to the State under subsection (s) for the quarters in the previous fiscal year.

(3) Only for the purpose of computing under this subsection the Federal share of expenditures for a State for fiscal year 1984 (in the case of the payment which may be made for the first quarter of fiscal year 1985), the Federal medical assistance percentage for fiscal year 1984 shall be the Federal medical assistance percentage for States in effect for fiscal year 1983, disregarding any change in such percentage between fiscal year 1983 and fiscal year 1984.

(c)(1) Effective for calendar quarters beginning on or after October 1, 1984, subsection (s) of section [1902] *1903* of the Social Security Act (added by subsection (a) of this section) is repealed.

(2) Effective after payments for the first quarter of fiscal year 1985, subsection (t) of section [1902] *1903* of the Social Security Act (added by subsection (b) of this section) is repealed.

* * * * * * *

CHAPTER 3—MISCELLANEOUS CHANGES

REPEAL OF EPSDT PENALTY

SEC. 2181. (a) * * *

(b) The amendment made by subsection (a)(1) shall apply to reductions for calendar quarters beginning on or after June 30, 1974, and the amendments made by subsection (a)(2) shall take effect on October 1, 1981, *except that, in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order to incorporate the provisions required to be included by this section into such State plan, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to include the provisions required to be included in such State plan by subsection (a)(2) of this section before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act, but the requirements previously set forth in paragraphs (1) through (3) of section 403(g) of the Social Security Act (prior to its repeal by this section) shall apply under title XIX of such Act to such State on and after October 1, 1981, whether or not the provisions required to be included by this section in the State plan under title XIX have been incorporated into such State plan*

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Subtitle D—Maternal and Child Health Services Block Grant

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REPEALS AND CONFORMING AMENDMENTS

SEC. 2193. (a) * * *

* * * * * * *

(c)(1) Section 1108(d) of the Social Security Act is amended by striking out "section 502(a)" and all that follows through "1967" and inserting in lieu thereof "section 421".

(2) Section 1101(a)(9)(D) of such Act is amended by striking out "V, XVIII, and XIX" and inserting in lieu thereof "XVIII and XIX".

(3) Section 1122 of such Act is amended—

(A) by striking out "V, XVIII, and XIX" and inserting in lieu thereof "XVIII and XIX" each place it appears, and

(B) by striking out "V, XVIII, [or X"] *or XIX*" in subsection (d)(2) and inserting in lieu thereof "XVIII or XIX".

* * * * * * *

SECTION 914 OF THE OMNIBUS RECONCILIATION ACT OF 1980

COORDINATED AUDITS UNDER THE SOCIAL SECURITY ACT

SEC. 914. (a) * * *

(b)(1) Section 1902(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (40);

(B) by striking out the period at the end of paragraph (41) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (41) the following new paragraph:

"(42) provide (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for such entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).".

(2)(A) The amendments made by paragraph (1) shall (except as provided under subparagraph (B)) apply to [medical assistance provided, under a State plan approved under title XIX of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act.] *cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title XIX of the Social Security Act.*

(B) In the case of a State plan for medical assistance under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by paragraph (1), the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act.

(c)(1) Section 505(a) of such Act is amended—

(A) by striking out "and" at the end of paragraph (14);

(B) by striking out the period at the end of paragraph (15) and inserting in lieu thereof "; and"; and

(C) by inserting after paragraph (15) the following new paragraph:

"(16) provides (A) that the records of any entity participating in the plan and providing services reimbursable on a cost-related basis will be audited as the Secretary determines to be necessary to insure that proper payments are made under the plan, (B) that such audits, for entities also providing services under title XVIII, will be coordinated and conducted jointly (to such extent and in such manner as the Secretary shall prescribe) with audits conducted for purposes of such part, and (C) for payment of such proportion of costs of each such common audit as is determined under methods specified by the Secretary under section 1129(a).".

(2) The amendments made by paragraph (1) shall apply to [services provided, under a State plan approved under title V of the Social Security Act, on and after the first day of the first calendar quarter beginning more than 30 days after the date of the enactment of this Act] *cost reporting periods, beginning on or after April 1, 1981, of an entity providing services under a State plan approved under title V of the Social Security Act.*

XIII. Dissenting and Supplemental Views of H.R. 6877

SUPPLEMENTAL VIEWS OF CONGRESSMAN TOBY MOFFETT

It is extremely difficult for me to support this package which cuts an additional $2.146 billion from our Nation's health care program. Once again, we are asking those in our society who are among the most vulnerable and most needy to pay the price for a tax and defense spending program which is unwise and an abject failure. It strikes me that we approach health care cuts in a manner strikingly similar to our handling of the defense budget; in defense, we set a percentage increase and look for things to buy; in health care, we set a target for reduction and look for victims to suffer the consequences.

In contrast to last year's Reconciliation Act, this year we saw a surprising level of good will and comity marking the negotiations which led to the construction of this legislation. And, some positive decisions were made.

I oppose the institution of mandatory copayments. This package makes such copayments optional to the States, under Medicaid, and provides appropriate exemptions for children, pregnant women, emergency services, family planning, and institutionalized individuals.

Under Medicare Part B, the Committee makes reductions in physician reimbursement levels, except for those physicians who take assignment. For years, I have been working, in Connecticut and as a Member of the Committee, on various proposals which would boost the number of physicians who take assignment. It is somewhat ironic that the Committee has finally acted to do something about this problem in a Reconciliation package which cuts Medicare funding. I would hope that our interest in assignment rates would continue into the next Congress, and that we would increase health care opportunities for the elderly by using other means to increase the assignment rate.

We have been told that these additional health care cuts are necessary because of the skyrocketing level of inflation in the health care industry. These increases drive up Federal expenditures. Following this argument to its extreme, there may be a time when we eliminate all Federal health care assistance because we have not acted against the persistent inflation levels found among hospitals, providers, medical technology, and suppliers.

In November, 1979, we were told that a hospital cost containment approach at the Federal level was inappropriate and that a voluntary scheme would do the trick. Now we are confronted with two consecutive years of doublt-digit increases in health care costs; and, we heard testimony recently before our Health Subcommittee that the voluntary system simply has not worked.

Despite over thirty years of effort beginning with the Truman Administration, there has been no progress in forming a national health insurance proposal. While I have concerns about certain elements of this suggestion, it's hard to believe that we haven't been able to harmonize the interests of physicians, consumers, hospitals, and insurance companies and make some meaningful progress.

There are a number of proposals pending before the Congress which would move us toward a system of prospective reimbursement. Under this system of budgeting, using Federal Medicare and Medicaid funds, hospitals could arrange their purchasing of supplies, services and so forth, and do so with cost-effectiveness and planning. But this package does not include such a meaningful reform.

We are concerned about the cost of taking care of elderly people and poor people who are sick. Yet, we do nothing to reduce the incidence of illness. Pending before this Committee is legislation which would require food manufacturers to provide information relative to sodium in their products. We know that excessive use of salt leads to hypertension. The incidence of stroke and heart attack which results costs us $8 billion annually. By reorienting the diets of the people in this country we could save a substantial portion of the dollars which are being cut in this legislation. Indeed, sodium labeling legislation could have a more significant impact, in terms of lowering overall health care costs, than the legislation which the Committee reported.

In conclusion, it appears to me that we are losing the distinction between the cause of the illness of health care inflation and its symptoms. The causes of health care inflation are numerous—overbuilding, overbedding, overutilization of facilities, unwise reimbursement schemes, etc. Finding a solution to these and other problems will not be easy. But we shouldn't delude ourselves into believing that health care cost inflation will be arrested by cutting people off at the needs.

As I said earlier, many of the proposals here are balanced, thoughtful and offered in the spirit of shielding children, the institutionalized and pregnant women from further punitive reductions in benefits. But if this package prevails, we shouldn't believe that health care inflation, or the Federal deficit, will disappear. To take care of those ills, we will have to do some major surgery on the health care delivery system—and on the President's economic program—to really make our mark.

Toby Moffett.

DISSENTING VIEWS OF REPRESENTATIVE WILLIAM E. DANNEMEYER TO H.R. 6877, JULY 30, 1982

While it is encouraging to note that the Energy and Commerce Committee has been able to report a reconciliation measure this year, in contrast to what happened last year, the work product of H.R. 6877 still leaves a bit to be desired. Indeed, its deficiencies are sufficient enough to threaten the credibility, if not the viability, of the congressional budget process.

When the Congress passed the First Concurrent Resolution on the 1983 Budget, it included instructions to its committees to make the cuts necessary to implement the resolution. For its part, the House Energy and Commerce Committee was instructed to cut $674 million from entitlement programs—Medicaid and Medicare—in 1983 and $2.22 billion over the three year period, 1983–1985. However, H.R. 6877 only cuts entitlement programs within its jurisdiction by $508 million the first year and by $2.06 billion over the three year period. Thus, we are in the position of undercutting reconciliation instructions that, even if fully implemented, will still leave us with a $104–$114 billion Federal deficit in fiscal year 1983. As a matter of principle, that is something I cannot support. At the very least, H.R. 6877 should have fulfilled the reconciliation instructions and, given our budgetary problems, one would have hoped that it would have exceeded them.

If there were no possible way of cutting the Medicare and Medicaid programs any more than $508 million, perhaps an "aye" vote would have been justified. However, such was not the case. More could have been done to encourage the States to reduce their error rates. The double subsidy that occurs when Federal medicaid funds are used by States to buy Medicare Part B coverage for cash assistance Medicaid recipients could have been eliminated. The special matching rate for family planning services could have been reduced to the regular rate. And those are only a few of the possibilities that could have been employed without depriving truly needy people of essential benefits. Granted, some of these options would not have been all that popular, but with budget deficits and Federal borrowing soaring, interest rates threatening to go higher and the spectre of renewed inflation looming in the background if we do not cut spending, the time for tough decisions has come. We simply cannot go on talking about cutting the budget but then postponing the day we actually do it to the extent necessary.

There are several other things about H.R. 6877 that give reason for concern. One is that it includes a provision allowing states to continue Medicaid coverage for those no longer eligible for AFDC benefits as a result of last year's budget reconciliation act. Aside from the fact that this amounts to undoing one of the "savings" achieved after so much effort last year, it is interesting to note that the cost estimates

this year for the proposal are lower than they were last year when the proposal was a "cut," not an "add." Hopefully, this does not mean actual expenses will outrun projection but it does serve as a reminder that there is a tendency at times to make optimistic claims with respect to savings or cost estimates. That being the case, we would have been better off to come up with more, rather than fewer cuts, just in case some of the projected savings do not materialize.

All in all, this bill is a step in the right direction, but not a big enough step. More cuts are needed, and it is my hope that they will be provided for at some future point in the legislative process.

WILLIAM E. DANNEMEYER.

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